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DEPARTMENT OF Managed Healthcare

State of California

Application for an Award of Advocacy and Witness Fees

Entity Name:	Health Access of California
Proceeding:	2002-0018 General Access/ 2005-0203 Timely Access
Date Submitted:	3/16/2010 4:42:31 PM
Submitted By:	Rick Pavich
Application version:	Original App

1. For which proceeding are you seeking compensation?

   2002-0018 General Access/ 2005-0203 Timely Access

2. What is the amount requested?

   $142,510.00

3. Proceeding Contribution:

   Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

   Health Access: Unique Contribution to Timely Access Health Access California did the following thing: • We were the organization that sponsored the original legislation, working with interested parties to craft the measure in 2003. • We have been the primary proponent of time-elapsed standards as the measure of timely access. This was the approach adopted by the Department in its deliberations. • Our questions and probing prompted the discovery that each health care service had been filing its own self-defined time-elapsed standards since the creation of Knox-Keene in 1975 but the plans had no means of demonstrating compliance with those standards. We also prompted the Department to compare the pre-existing, self-imposed time-elapsed standards of the major health care service plans, revealing substantial consistency among these standards. • We helped to craft the enforcement approach, making a vigorous case that consumer satisfaction surveys alone are not sufficient and that other scientifically valid means of determining compliance were necessary and appropriate. • We contributed significantly to the standard for triage, providing the policy rationales of reducing emergency room crowding and assuring clinically appropriate timely care when a consumer needs assistance in determining whether they are facing an emergency or can wait until the next day to obtain care. • We also provided the policy argument that meaningful timely access standards should reduce inappropriate emergency room utilization by persons with coverage, thus relieving worsening emergency room crowding. • We contributed significantly to the provisions of the regulation that provide an assessment of existing network adequacy. We also were the primary proponents of revisiting and making meaningful the existing regulation on the ratio of primary care physicians to enrollees. The department did not adopt our proposal but did include provisions that will allow the department greater capacity to determine network adequacy.

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I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at Sacramento (City), CA (State), on March 16, 2010 .

Enter Name: Rick Pavich

HEALTH ACCESS

ELIZABETH ABBOTT joined Health Access in January 2006 as their Project Director where she focuses on federal health programs and the impact they have on beneficiaries and public policy in California. She previously served as the Regional Administrator of the Centers for Medicare and Medicaid Services (CMS) in Region IX which serves the states of California, Arizona, Nevada, Hawaii, and the Far Pacific (including the Pacific Trust Territories of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.)

She was responsible for the oversight of State Medicaid agencies, State survey and provider certification operations, State Children's' Health Insurance Programs, and managed care organizations. The San Francisco Region spans a vast geographic area, has one of the most culturally diverse populations in the nation, serves over 10 million beneficiaries, and has a programmatic budget exceeding $30 billion per year.

Ms. Abbott joined CMS as the Associate Regional Administrator for Medicare in 1993 where she managed technical, clinical, and financial staff and oversaw Medicare contractors that serve providers and beneficiaries in the West. Prior to joining CMS, she worked in progressively more responsible positions with the Social Security Administration (SSA) in 17 field and regional offices in Massachusetts, Connecticut, Illinois, Indiana, and throughout California.

Ms. Abbott has a B.A. in psychology from the University of Redlands in Redlands, California and has done graduate work in public administration at the University of Southern California.

Billing Rate Classification: Non-Attorney Expert; 13+ years

BETH CAPELL, PH.D., *Capell & Assoc.* has been the principal and owner of Capell & Assoc. since its founding in 1995. She has thirty years of experience in Sacramento, working in the Legislature, various Administrations, and with various interest groups.

She represents Health Access California; Health Access Foundation; the California Physicians Alliance; State Council of Service Employees International Union, AFL-CIO; and other consumer and labor organizations in both legislative activity and regulatory action.

Health Access California sponsored the package of legislation known as the HMO Patient Bill of Rights from 1995 to its enactment in 1999. Health Access Foundation led a collaborative of consumer groups that monitored initial implementation of the more than 20 pieces of legislation enacted between 1995 and 2000 intended to protect consumers from HMOs. Health Access Foundation has continued to work on implementation and ongoing monitoring of the law with respect to consumer protections against HMOs. Beth Capell has been an architect and active advocate throughout this decade of efforts.

Beth Capell has worked on issues including prescription drugs, universal access, hospital overcharging, balance billing by physicians, nursing home regulations, hospital standards, health insurance regulation, and other health care issues.

Prior to establishing Capell & Assoc. Beth Capell represented the California Nurses Association from 1986 to 1995, first as the legislative advocate and later as the Director of Government Relations for the association. From 1983 to 1986, Ms. Capell worked at the California Manufacturers Association, working on job training and human resource issues, including health insurance. From 1977 to 1983, Ms. Capell worked in various positions in the Legislature, the Administration, and other efforts.

Ms. Capell has Ph.D. in political science from the University of California, Berkeley, and continues to publish articles and present papers on political science, specifically interest groups, legislatures, and the impact of legislative term limits.

Billing Rate Classification: Non-Attorney Expert; 13+ years

ANTHONY WRIGHT serves as Executive Director for Health Access California, the statewide health care consumer advocacy coalition, working on behalf of the insured and uninsured, made up of organizations representing seniors, children, working families, people with disabilities, immigrants, people of faith, labor, and communities of color.

Under Wright's leadership since 2002, Health Access has been a leader in efforts to fight health care budget cuts, to expand both employer-based coverage and public insurance programs, to advance consumer protections, and to address the causes of medical debt. For example, his work on hospital overcharging and abusive billing and collections practices led to both to legislative action and hospital guidelines on the issue. Recently, he served as co-chair and campaign manager for the No on 78/Yes on 79 initiative effort, facing the prescription drug industry and the most expensive ballot campaign in the nation's history.

Wright's background is as a consumer advocate and community organizer, and he has been widely quoted in local and national media on a range of issues. He served as Program Director for New Jersey Citizen Action. As coordinator of New Jersey's health care consumer coalition, he ran successful campaigns to win HMO patient protections, defeat for-profit takeovers of nonprofit hospitals and Blue Cross Blue Shield, pass a law to govern hospital conversions and acquisitions, and expand coverage for low- and moderate-income children and parents.

Wright also worked at the Center for Media Education in Washington, DC, *The Nation* magazine in New York, and in Vice President Gore's office in the White House. Born and raised in the Bronx, Wright graduated from Amherst College magna cum laude in both English and Sociology.

Billing Rate Classification: Non-Attorney Expert; 7- 12 years

HEALTH ACCESS

March 5, 2007

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Stephen Hansen, Staff Counsel
Suzanne Chammout, RN, JD, Regulation Coordinator

Re: Adopting title 28, California Code of Regulations section 1300.67.2.2-
Timely Access to Health Care Services, Control No. 2005-0203

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on and amendments to the proposed regulations on. These regulations result from AB2179 (c. of 2002) by Assemblymember Rebecca Cohn.

We appreciate the opportunity to comment before the Department at the public hearing today. However, we were surprised at the amount of opposition to these proposed regulations from the plans and associations since the expectation that the consumer would receive timely access to health care has been in existence for the last 30 years. In addition, the legislature reaffirmed that expectation of timely access to care in the language of AB2179. Particularly in light of the lengthy time since enactment, it was disappointing that the plans and associations were surprised that the Department was going forward with the regulatory process. They also could not offer any concrete suggestions or language for alternative standards or practical means to monitor compliance. Despite the plans' stated opposition, we believe that specific time-elapsed standards such as these would be the only mechanism for the Department to ensure its goal of timely access to health care.

We begin by noting that we are generally supportive of the proposed regulations as written. However, we also suggest specific amendments and corrections.

1. The Inter-relationship Between Cultural and Linguistic Access to Care and Timely Access Regulations

We wish to comment on the discussion at the public hearing today which highlighted the perceived conflict between the Department's recent approval of the Cultural and Linguistic Access to Care regulation with this proposed regulation governing timely access. Health Access believes that low English proficient consumers should be entitled to timely access to care **and** that care should be delivered in a language that the patient can understand. We do not believe that consumers should have to choose between those rights or that providers should be permitted to make that choice for them. There are both federal and state statutes that would see that practice as discriminatory. We believe that there are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including Video Medical Interpretation (VMI).

2. S.1300.67.2.4 (a) (1) Provide Timely Care: Individual Cause of Action

Health Access asks that this section be amended by striking the following:

> (1) Provide Timely Health Care. All health care service plans, including specialized plans (plans), shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with professionally recognized standards of practice. If plan providers provide appointments on a "same-day access" basis, as defined in subsection (b)(6), the plan will be in compliance with the requirements of this section in regard to providers operating on a same-day access basis. ~~*This section is not intended to create any basis for an individual cause of action not presently existing in law and is not intended to apply to emergency medical conditions and emergency care which are regulated and governed by other applicable law including Health and Safety Code section 1317.1.*~~ However, this section applies to timely access to needed health care services after the enrollee has received emergency services and has been stabilized, as described in section 1374.1 of the Act and section 1300.74.1 of the regulations.

There is no statutory basis for the sentence stating that this section is not intended to create any basis for an individual cause of action. Indeed, the Legislature in its deliberations could have added such a provision and expressly failed to do so. Instead the Legislature has expressly permitted litigation against health plans (SB21 Figueroa, c. 536 of 1999) to allow litigation against health care service plans for the failure to exercise ordinary care.

> Civil Code 3428. (a) For services rendered on or after January 1, 2001, a health care service plan or managed care entity, as

> described in subdivision (f) of Section 1345 of the Health and Safety Code, shall have a duty of ordinary care to arrange for the provision of medically necessary health care service to its subscribers and enrollees, where the health care service is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care when both of the following apply:
>
> (1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee.
>
> (2) The subscriber or enrollee suffered substantial harm.

The Legislature which enacted AB2179 in 2002 was well aware of the action it had taken in 1999.

The offensive sentence regarding individual cause of action has no statutory basis and indeed its inclusion contradicts the legislative history. It should be stricken.

3. S. 1300.67.2.2 (a) (3) Delegation and Responsibility

AB2179, c. of 2002, amended S.1342 of the Health and Safety Code by adding:

> *S.1342: The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.*

While this language applies to all provisions of the Knox-Keene Act, it was specifically enacted in conjunction with the timely access provisions. Thus the proposed regulation on delegation and responsibility has the strongest possible statutory basis.

4. S. 1300.67.2.2 (b) Definitions

Health Access is supportive of the proposed definitions and has worked with the Department and other interested parties in the development of these regulations.

5. S. 1300.67.2.2 (c) Timely Access Program Requirements

Health Access supports time-elapsed standards as proposed in this section. AB2179 stated:

> S.1367.03 (c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care

and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

The Department has engaged in a lengthy process of reviewing timely access to care, a process that began concurrently with the legislative process and that included several meetings of the advisory committee to the Department with lengthy public presentations on timely access as well as numerous private meetings with interested parties.

Since the enactment of the Knox-Keene Act in 1975, health care service plans have been obliged by S. 1367 (e) to assure that "all services shall be readily available at reasonable times to all enrollees". In developing the timely access program requirements, the Department reviewed the standards for timely access that the plans had filed with the Department for *three decades* and proposed standards for timely access that were substantially consistent with those imposed by the plans on themselves. If plans have failed to comply with their own standards, and years of complaints by consumers suggest this is the case, that is what the statute and these regulations are intended to remedy.

6. S.1300.67.2.2 (c) (3) Timely Telephone Access

Health Access supports the requirement for timely telephone access to a qualified health professional, acting within scope of practice, who is trained to screen and triage.

We support those provisions that provide for access within 10 or 15 minutes. Consumers are not clinicians. It is unreasonable to expect a reasonable person to be able to determine whether a condition is an emergency or not. Indeed often the call to the doctor is precisely for that reason. In the Utterback case, which prompted one of the largest fines in the Department's history, the initial problem was the failure to be promptly triaged or screened.

We ask that those provisions that provide for access within 30 minutes be amended to 15 minutes. Emergencies strike during non-business hours as well as Monday through Friday, 9 to 5. Good clinical practice dictates that prompt response to heart attacks, strokes, severe injury and other life-threatening conditions occur within an hour. In emergency care, this is known as the "golden hour": if a patient can access care within that hour, the odds of recovery and indeed survival increase dramatically. Eating up half that hour waiting for triage is bad care. We recognize that the Department is attempting to accommodate providers in allowing 30 minutes to respond. However, the point of the Knox-Keene Act is not to accommodate providers but to assure that consumers can receive care when they need it. Nowhere in the Knox-Keene Act

does it state that the convenience of doctors is more important than the care of patients.

7. S.1300.67.2.2 (d) Alternative Standards

We reluctantly accept the notion that alternative standards may be proposed and approved. We suggest the following additions to this section to improve consumer protections.

First, in (d) (1) and throughout, we suggest that "provider ~~shortage~~" be corrected to "provider *availability*". While there are certainly areas of chronic provider shortage, over the last three decades there have been instances of provider surplus as well as provider shortage. Since these regulations are intended to be in place for more than the next few years, the language of the regulations should admit the possibility of surplus as well as shortage.

Second, under (3) Justification, we ask that a new provision be added regarding the clinical appropriateness of the proposed alternative standard. All of the proposed provisions under justification have to do with provider availability. While AB2170 and the Knox-Keene Act more generally recognizes availability as a legitimate concern, AB2179 specifically directs the Department to consider "clinical appropriateness" (S.1367.03 (b) (1)) in developing these standards.

Third, this section appears to contemplate alternative standards as one-time events. We suggest that plans may wish to renew alternative standards. We suggest the addition (4) Renewal of Alternative Standards as follows:

(4) Renewal of Alternative Standards: A plan may seek to have an alternative standard renewed through a material modification. In doing so, the plan shall demonstrate that the alternative standard has assured compliance with S.1367.03 of the Act. The plan shall review any history of complaints about lack of timely access, its history of compliance with the alternative standard and any other indicators of lack of clinically appropriate care.

8. S.1300.67.2.2 (e) Compliance Monitoring

Health Access acknowledges that this section now requires plans to demonstrate valid and reliable methodology for compliance monitoring. The science of statistics and survey methodology is well established: reliability and validity are

scientific terms that have precise meaning. We commend the Department of the inclusion of this provision.

Again, we suggest that "provider ~~shortage~~" be replaced with "provider availability". (4) (C).

9. S.1300.67.2.2 (f) Enrollee Satisfaction Survey

The satisfaction survey, including the questions asked, must be publicly available documents. The CAHPS survey is not a publicly available document: it is instead the creation of a private industry entity.

10.S.1300.67.2.2 (k) No New Cause of Action

Health Access asks that this section be stricken in its entirety. There is no statutory basis for this section. Indeed, the Legislature in its deliberations could have added such a provision and expressly failed to do so. Instead the Legislature has expressly permitted litigation against health plans (SB21 Figueroa, c. 536 of 1999) to allow litigation against health care service plans for the failure to exercise ordinary care.

Civil Code 3428. (a) For services rendered on or after January 1, 2001, a health care service plan or managed care entity, as described in subdivision (f) of Section 1345 of the Health and Safety Code, shall have a duty of ordinary care to arrange for the provision of medically necessary health care service to its subscribers and enrollees, where the health care service is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care when both of the following apply:
(1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee.
(2) The subscriber or enrollee suffered substantial harm.

The Legislature that enacted AB2179 in 2001 was well aware of the action it had taken in 1999. The offensive section regarding individual cause of action has no statutory basis and indeed its inclusion contradicts the legislative history. It should be stricken.

Timely access to care remains one of the principal complaints from consumers Consequently, we look forward to working closely with the Department on the monitoring and enforcement of this regulation.

If you have questions or need further information, please contact Beth Capell, Capell & Associates, at (916) 497-0760 or Elizabeth Abbott at Health Access at (916) 497-0923.

Sincerely,

Anthony Wright
Executive Director

CC: Senator Mike Machado, Chair, Senate Banking, Finance and Insurance Committee
Assemblymember Mervyn Dymally, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care

HEALTH ACCESS

September 21, 2007

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Stephen Hansen, Staff Counsel

Re: Adopting title 28, California Code of Regulations section 1300.67.2.2-
Timely Access to Health Care Services, Control No. 2005-0203

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on and amendments to the proposed regulations on. These regulations result from AB2179 (c. of 2002) by Assemblymember Rebecca Cohn.

We appreciate the opportunity to comment at the public hearing on September 18, 2007. In addition, we offer these written comments to The Department. We begin by noting that we are generally supportive of the proposed regulations as written. However, we also suggest specific amendments and corrections.

1. Affirmation of Time-Elapsed Standards

At the public hearing we were surprised at the amount of opposition to these proposed regulations from the plans and associations. We believe it is clear that for the last 30 years it has been the expectation that the consumer would receive timely access to health care. In addition, the legislature reaffirmed that expectation of timely access to care in the language of AB2179, enacted in 2002, five years ago. During 2002, during the development of AB2179, in addition to hearings in the legislative process, the advisory committee to the Department held more than three hearings on timely access to care, hearings that demonstrated both that it was possible to provide timely access and that the need for standards existed.

Particularly in light of the lengthy time since enactment of AB2179 and the extensive process of seeking input by the Department as well as the Legislature, Health Access is disappointed that the plans, providers, and associations are surprised that the Department is going forward with the regulatory process. Indeed, the law requires the Department to have completed these regulations no later than January 1, *2004, almost four years ago.* The suggestion that The Department begin the regulation process from

the beginning again is completely without merit and is directly contrary to statutory obligation on the Department.

AB2179 in Sec. 1367.03 (c) states that

> The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtain care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate.

No one has demonstrated that any other standard is more appropriate in terms of meeting the obligations of the Knox-Keene Act.

It is clear that despite The Department's specific request in the **Solicitation of Comments**, no one at the hearing could offer any concrete suggestions or language for alternative standards or practical means to monitor compliance. Many speakers argued that they were already providing exemplary timely access to care, in which case they should have no problem achieving and even exceeding these standards.

Since the enactment of the Knox-Keene Act in 1975, health care service plans have been obliged by S. 1367 (e) to assure that "all services shall be readily available at reasonable times to all enrollees". In developing the timely access program requirements, the Department reviewed the standards for timely access that the plans had filed with the Department for *three decades* and which providers had allegedly complied with for over thirty years (see attachment). The regulations proposed by the Department are based on standards for timely access that were substantially consistent with those imposed by the plans on themselves. If plans have failed to comply with their own standards, and years of complaints by consumers suggest this is the case, that is precisely what AB2179 and these regulations are intended to remedy. Despite the plans' stated opposition, we believe that specific time-elapsed standards such as these would be the only mechanism for the Department to ensure its goal of timely access to health care.

We further note that many speakers argued that these regulations were unnecessary because of the relatively small number of formal complaints on timely access to care registered by The Department. It is clear that The Department is not the sole repository of consumer complaints, and the statistics the speakers referred to did not include *inquiries* to DMHC or complaints registered with a myriad of consumer organizations, legal advocacy organizations, or directly to the plans and providers themselves. In addition, we believe that not all consumers are fully versed on their rights and take a delay or denial in receiving care for themselves, a family member or friend with resignation and make no further inquiry or register any kind of complaint at all. Consequently, the number of formal complaints filed with DMHC is at best a partial and imperfect measure of the lack of timely access.

2. Substantial Compliance in Provider Shortage Situations

Health Access is opposed to the language providing an open-ended exemption from compliance with timely access standards in provider shortage situations. This is an exemption that could make meaningless all of the other requirements of these regulations and other basic provisions of the Knox-Keene Act. This exemption says that the plan must attempt to remedy the shortage of providers, but does nothing to set timelines or force other action, such as withdrawal from a geographic region where the plan is unable to provide timely access.

Indeed the provision allowing an unlimited exemption from timeliness of access raises in our minds grave concerns as to whether the Department is meeting its statutory obligation to assure adequate networks by plans in their respective service areas.

Adequacy of network is one of the fundamental principles of the Knox-Keene Act. Plans that are unable to demonstrate adequate networks have been required to withdraw from geographic regions in which they are unable to provide adequate access to care or refused permission to add covered lives.

Plans are able to rectify provider shortages by a variety of means including providing increased compensation to recruit and retain an adequate number and mix of providers, enhanced use of technology, and utilization of out-of-network specialty consultations, among others. Provider shortages are largely a product of plan failure to compensate providers adequately and to treat them respectfully. It is said there is never a labor shortage, just a wage shortage or a working condition shortage.

We are particularly unsympathetic to those medical group administrators that have testified again and again over a period of years that they are unable to rectify provider shortages. Their failure to provide timely care and an adequate network merits enforcement action. Consumers should not be put at risk of lack of care because of the incapacity of administrators.

We note that California has successfully implemented standards for nursing care in both hospitals and nursing homes. In late 2003, regulations were finalized requiring nursing ratios in hospitals. In 2004, the hospital association attempted various maneuvers to delay or make meaningless these requirements. The various legal battles ended early in 2005. Attached is a chart from a 2007 report by the California HealthCare Foundation that demonstrates that nursing care increased from 7.5 hours per patient day in 2001 to 8.5 hours per patient day in 2005. In 2004, use of registry or temporary nursing staff increased significantly over historic levels but by 2005, use of registry had reverted to the more usual levels. This was done despite a shortage of registered nurses not only in California but across the country. Indeed Kaiser Permanente which implemented

nursing ratios in advance of the requirement, increased wages and made other improvements in working conditions (such as allowing meal breaks!) was able to come into compliance even more quickly. If hospitals can obey the law, so can medical groups and health plans.

S.1367.03 (d) gives the Department no statutory authority to exempt plans from standards on timeliness of access. Indeed, S.1367.03 (d) is quite clear that "if the department finds that health care service plans and health care providers are having difficulty in meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature". By this language, the Legislature made plain that the department could only return to the Legislature for further action and the department lacks statutory authority to grant exemptions due to provider shortages.

3. Standards Regarding Telephone Triage

In 1300.67.2.2 (c) (3) the Department stipulates that consumers must be able to speak with a plan representative for a referral, to register a complaint, or to request telephone triage. However, much of this language implies that it is optional for a plan to provide services after hours. Telephone triage is care: it is subject to 1367.03 (c). Indeed telephone triage is often the first effort by an enrollee to seek care and thus plainly must be governed by a "standard", not a "guideline". Again 1367.03 (c):

> If the department chooses a standard other than the time elapsed between the time an enrollee *first* seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate.

Triage is by definition the first moment when an enrollee seeks care.

All health plans and all contracting providers should be required to provide prompt telephone service during business hours and telephone triage after hours. The need for health care does not occur only between 9:00 am and 5:00 pm, Monday through Friday. Timely access to care requires that consumers, who are not clinicians, have access to a health care professional who is trained to screen and refer them for emergency or urgent care when appropriate or simply to assure them that they can safely wait until the morning to be seen. A new mother with a baby with a high temperature or vomiting may not know whether her child needs care, a spouse with a partner with shortness of breath may not know what needs to be done, a family friend with an injury may not know whether they need to be seen urgently. These are precisely the kinds of cases AB2179 was intended to address.

We also take note that 85% of those who use emergency rooms have coverage of some sort, either Medi-Cal, Medicare or commercial insurance. Directing insured consumers to emergency rooms for triage of non-emergent conditions is wasteful and

avoidable. These regulations should assure that consumers can get timely access to triage without being forced to use an emergency room.

If an enrollee does not have access at all times to a health professional that is licensed to triage so that an enrollee is forced by the lack of adequate network to be triaged in an emergency room, then the consumer should have no financial barriers to the use of emergency room care. Health plans cannot create financial barriers to the use of emergency room care and at the same time direct consumers to go to the emergency room for basic triage. This is an unacceptable Catch-22 where the consumer always loses, facing a choice between their money and their life. We would prefer that plans and providers provide access to telephone triage 24 hours a day, seven days a week rather than sending consumers to overcrowded emergency rooms. We note that this 24 hour/7 days per week standard is one the Department itself meets at its own HMO Help hotline.

4. The Inter-relationship Between Cultural and Linguistic Access to Care and Timely Access Regulations

We wish to comment on the discussion at the public hearing that highlighted the alleged conflict between the Department's recent approval of the Cultural and Linguistic Access to Care regulation with this proposed regulation governing timely access. Health Access believes that low English proficient consumers should be entitled to timely access to care **and** that care should be delivered in a language that the patient can understand. We do not believe that consumers should have to choose between those rights or that providers should be permitted to make that choice for them. There are both federal and state statutes that would see that practice as discriminatory. We believe that there are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including Video Medical Interpretation (VMI).

5. Alternative Standards; Material Modification

In 1300.67.2.2 (d) the Department outlines a method for plans to propose alternatives to the timely access standards specified. In addition, this section describes the process, to last for not more than three years, and the option of how to request a continuation of the alternative standard beyond that time if the circumstances are not remedied. This provision appears to enable a plan to adopt an alternative, more lenient standard with the Department's concurrence that would last for years.

One of the benchmarks by which the Department is to assess an alternative standard is whether the proposed alternative standard is "more appropriate". Since all too often plans and providers translate "more appropriate" as more convenient for the plan or the

provider, ignoring the needs of the consumer; this should specify that the proposed alternative is more appropriate for the consumer.

In addition, the principal approval mechanism for this deviation from requirements to provide true timely access would be a material modification to the plan's license. We have serious objections to the process as outlined. The material modification is an internal procedure that is not open to public comment or scrutiny. It would potentially provide plans that will not or cannot meet the timely access standard to evade their responsibility to do so.

6. Follow-up Auditing

In 1300.67.2.2 (e) the Department stipulates that if the plan has reason to question the validity, credibility, or veracity of the responses to the monitoring of providers, the plan shall undertake to resolve these discrepancies. Health Access believes that careful monitoring of timely access to care is essential and this requirement for plan oversight and verification is critical. We would argue, in addition, that a similar provision be entered in this section to specify that the Department should undertake to verify the reliability of information supplied by health plans when there is reason to question its validity, credibility, or veracity or the Department otherwise believes that additional verification is appropriate.

7. Compliance Monitoring

In 1300.67.2.2 (e) the plans are permitted to use a wide variety of techniques to monitor timely access. We noted the testimony at the hearing that gave examples of where non-anonymous questions and surveying led to distorted answers. This was particularly problematic in terms of results when the provider learned that the questioner was the plan and not a patient/consumer. We believe non-anonymous surveying should not be permitted because it is not a valid indicator of access to care.

8. Revision of Standard for Urgent Mental Health Care

In 1300.67.2.2 (c) (2) (C) calls for access to urgent mental health care within 48 hours. In light of changes to this portion of the regulation and the testimony at the hearing, we urge you to reassess this standard to within 24 hours.

Timely access to care remains one of the principal complaints from consumers. Consequently, we look forward to working closely with the Department on the implementation, monitoring, and enforcement of this regulation.

If you have questions or need further information, please contact Beth Capell, Capell & Associates, at (916) 497-0760 or Elizabeth Abbott at Health Access at (916) 497-0923.

Sincerely,

Anthony Wright
Executive Director
Health Access

Lupe Alonzo Diaz
Executive Director
Latino Coalition for a Healthy California

CC: Senator Sheila Kuehl, Chair, Senate Health Committee
Assemblymember Mervyn Dymally, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care

HEALTH ACCESS

December 26, 2007

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Stephen Hansen, Staff Counsel

Re: Adopting title 28, California Code of Regulations section 1300.67.2.2-
Timely Access to Health Care Services, Control No. 2005-0203

Dear Ms. Ehnes,

Health Access California, the statewide health care consumer advocacy coalition of more than 200 consumer, community and constituency organizations, offers comments on and amendments to the proposed regulations on Timely Access to Health Care Services. These regulations result from AB2179 (c. of 2002) by Assemblymember Rebecca Cohn.

As the original sponsors of this legislation, we note our surprise and dismay at the Department's complete abandonment of the statutory intent of AB2179. The language contained in the third revision of the proposed regulation reflects virtually none of the essential standard-setting, compliance oversight, and enforcement remedies outlined in the law and the first and second versions of the regulation.

We believe it is so flawed that the only acceptable course of action would be to withdraw this language, and adopt the second version with the revisions described in our September 21, 2007 letter. The fact that the current version of the regulation consists of seven pages, as opposed to 25 pages in the previous version, we believe it reflects generally less specificity, fewer requirements, and vaguer standards.

It is now apparent with this third revision of the regulation that the Department has capitulated to industry pressure. Throughout this regulatory process, we witnessed the furious opposition voiced by plans, providers, and associations at the public hearings. We noted the more than 1,000 comments received by the Department describing the dire "unintended consequences" of finalizing the language of the earlier versions of the regulatory process. In fact, in light of such vocal opposition, we can find no rationale for DMHC's December 2007 version of the regulation that proposes weak standards,

multiple exceptions to those standards, and relies heavily upon self-regulation by the plans. The flexibility built into this version of the regulation would make it unlikely that the Department would undertake rigorous enforcement of timely access standards. The force of the industry's opposition to timely access should dictate the need for the Department to draft the regulation to provide a clearer mandate, establishing an unequivocal standard, undertaking vigorous enforcement, and preserving greater protections for the enrollees as intended by the statute, rather than the reverse.

The proposed regulations violate the statutory authority and specific statutory intent of AB2179, c. 797 of 2002. Specifically, the statute states that

> *If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate.*

The standards in the Knox-Keene Act are intended to protect consumers, not providers and plans. The Department has failed to demonstrate why the standards proposed in the Dec. 2007 revision are more appropriate for consumers.

Also, the Department has failed to demonstrate the manner in which the proposed standards meet the statutory intent. The lack of timely access is an indicator of other serious, systemic problems that affect the delivery of health care in our state and the health outcomes of enrollees. If consumers do not have timely access to care, this often reflects broader problems such as lack of adequate provider panels, fiscal distress of a plan or provider, or shifts in the health care needs of a population. Indeed most of the comments by plans and providers are demonstrations of precisely such systemic failures. These failures should warrant investigation and action by the department for failure to comply with other provisions of the Knox-Keene Act, such as adequacy of networks. These comments also raise questions as to whether plans can actually deliver on the promises they made when offering the coverage to purchasers such as employers, unions, agencies, and individuals.

Our specific comments are as follows:

1. **Affirmation of Time-Elapsed Standards Set by The Department of Managed Health Care**

We argue strenuously that the Department reinstate the timely access to care standard as envisioned in the language of the legislation. We believe the timely access to care was a fundamental right outlined in the original Knox-Keene Act in 1975. The legislature reaffirmed that expectation of timely access to care in the language of AB2179, enacted in 2002. Since the enactment of the Knox-Keene Act, health care service plans have been obliged by S. 1367 (e) to assure that "all services shall be

readily available at reasonable times to all enrollees". In developing the timely access program requirements, the Department reviewed the standards for timely access that the plans had filed with the Department for *three decades* and which both plans and providers had allegedly complied with for over thirty years (see attachment). The regulations previously proposed by the Department were based on standards for timely access that were substantially consistent with those the plans say they imposed on themselves. If plans have failed to comply with their own standards, and years of complaints by consumers suggest this is the case, that is precisely what AB2179 and these regulations are intended to remedy.

We are therefore surprised at the level of industry opposition in light of the many legislative hearings, the lengthy time since enactment of AB2179, and the recent extensive process of seeking input by the Department. During the development of AB2179, in addition to hearings in the legislative process, the advisory committee to the Department held more than three hearings on timely access to care. Indeed, the law requires the Department to have completed these regulations no later than January 1, *2004, almost four years ago.* Many plans and providers publicly testified that they were already providing exemplary timely access to care, in which case they should have no problem achieving and even exceeding these standards.

We find the provision in the third version of this regulation allowing each plan to develop their own timely access to care standard constitutes the establishment of **no standard at all**. We think it would be likely that the providers who actually deliver the care under the so-called "delegated model" throughout a large part of California would be very unclear as to which standard they would have to meet. It is typical for a medical practice or medical group to contract with several health service plans, each of whom under this version of the regulation would be free to establish their own individual timely access standards. If the timely access standard were so loosely designed as to be set by individual plans for their contracted providers, some of them would certainly be in conflict with each other. In a contracting environment, it would be very difficult for providers to be sure of what standard they must meet for different patients. It would be virtually impossible for plans to monitor compliance with their own standards by their contracted providers who in all likelihood contract with other health plans as well. It would also result in an administrative nightmare when the Department attempted to monitor compliance with a confusing array of different timely access standards across plans. Based on this confusing patchwork of different standards being applied in any specific practice or medical group, this regulation would result in less timely access to care, rather than more, clearly not meeting any standard of complying with the legislative intent. In addition, we believe this regulation as written would not in any way meet the clarity standard for providers required to comply with it.

Therefore, despite the plans' stated opposition, we believe that specific time-elapsed standards issued by the Department would be the only mechanism for the Department to ensure its stated goal of timely access to health care.

2. Timely Access Standards Must Apply to All Health Plans

AB2179 explicitly states that it applies to health care service plans and specialized healthcare plans. While the March 5, 2007 and July 16, 2007 versions both include that broad applicability, the newest version dated December 10, 2007 restricts the regulation to plans that provide for hospital or physician services or mental health services pursuant to a contract with a full service plan. DMHC has waived applicability for time-elapsed standards to specialized plans including dental, vision, acupuncture, chiropractic or EAP plans. While the Department heard considerable public testimony complaining about the burden imposed on specialized plans, there is no such discretion or exception granted to the Department in the statute. DMHC asserts, without foundation, that application of this regulation to specialized plans is "not necessary to achieve the core objective of AB2179." We can cite no such latitude granted by the legislature in the underlying statute.

S.1367.03 (d) gives the Department no statutory authority to exempt plans from standards on timeliness of access. Indeed, S.1367.03 (d) is quite clear that "if the department finds that health care service plans and health care providers are having difficulty in meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature". By this language, the Legislature made plain that the Department could only return to the Legislature for further action and the Department lacks statutory authority to grant exemptions.

3. Standards Regarding Telephone Triage

In 1300.67.2.2 (d) (5) the Department stipulates that any plan that does not provide advanced access to appointments shall have specific systems and personnel in place. These require a qualified health care professional be available to screen or triage enrollees, advise regarding the time in which an enrollee should see a physician, to receive ancillary care services, or to facilitate arranging for appointments. However, this language states that these services should be available "during normal business hours." A different, substantially lower level of care is required for "after hours and weekends" which is limited to a requirement for a recorded telephone message.

All health plans and all contracting providers should be required to provide prompt telephone service during business hours and telephone triage after hours. The need for health care does not occur only between 9:00 am and 5:00 pm, Monday through Friday. Timely access to care requires that consumers, who are not clinicians, have access to a health care professional who is trained to screen and refer them for emergency or urgent care when appropriate or simply to assure them that they can safely wait until the

morning to be seen. A recorded message provides no opportunity to evaluate the medical condition or communicate with the enrollee. A new mother with a baby with a high temperature or vomiting may not know whether her child needs care, a spouse with a partner with shortness of breath may not know what needs to be done, a family friend with an injury may not know whether they need to be seen urgently. These are precisely the kinds of cases AB2179 was intended to address.

We also take note that 85% of those who use emergency rooms have coverage of some sort, either Medi-Cal, Medicare or commercial insurance. Directing insured consumers to emergency rooms for triage of non-emergent conditions is wasteful and avoidable. These regulations should assure that consumers can get timely access to triage without being forced to use an emergency room.

If an enrollee does not have access at all times to a health professional that is licensed to triage so that an enrollee is forced by the lack of adequate network to be triaged in an emergency room, then the consumer should have no financial barriers to the use of emergency room care. Health plans cannot create financial barriers to the use of emergency room care and at the same time direct consumers to go to the emergency room for basic triage. This is an unacceptable Catch-22 where the consumer always loses, facing a choice between their money and their life.

We would prefer that plans and providers provide access to telephone triage 24 hours a day, seven days a week rather than sending consumers to overcrowded emergency rooms. We note that this 24 hour/7 days per week standard is one the Department itself meets at its own HMO Help hotline.

Telephone triage is care: it is subject to 1367.01 (c). Indeed telephone triage is by definition the first effort by an enrollee to seek care and thus plainly must be governed by a "standard", not a "guideline". The Department must adhere to the provision in the law which states:

> *If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate.*

This regulatory language clearly does not comply with the statutory intent.

4. No New Cause of Action

The third revision of the regulation contains in S 1300.67.2.2 (a) (3) the provision that timely access to health care services "does not create a new cause of action or a new defense to liability for any person." Indeed, the Legislature in its deliberations could have added such a provision and expressly failed to do so. Instead the Legislature has

expressly permitted litigation against health plans (SB 21 Figueroa, c. 536 of 1999) to allow litigation against health care service plans for the failure to exercise ordinary care.

There is no statutory basis for this section, it contradicts the legislative history, and it should be stricken in its entirety.

5. Meaningful Standards for Enrollee Satisfaction Survey

The Department outlines requirements for quality assurance processes in (c) (2) (A) which include an "annual, statistically valid, enrollee satisfaction survey." DMHC stipulates that plans that use the CAHPS or ECHO survey instruments in connection with certification by NCQA may meet the requirements of this subsection by including appropriate supplemental questions as approved by the Department.

We would argue that to be a valid assessment, the satisfaction survey, including the questions asked, must be a publicly available document. The CAHPS survey is not a publicly available document; it is instead the creation of a private industry entity, available only at considerable cost, and not subject to either the open meetings law or the public records act.

6. Alternative Standards; Material Modification

In (e) (5) the Department outlines a method for plans to propose alternatives to the time-elapsed standards as a measurement of quality indicators specified. This provision appears to enable a plan to adopt an alternative, more lenient standard with the Department's concurrence and to allow that more lenient standard to remain in place for years with no review.

The Department states that "the burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards." Since all too often plans and providers translate "more appropriate" as more convenient for the plan or the provider, ignoring the needs of the consumer; this should specify that the proposed alternative is more appropriate <u>for the consumer.</u>

In addition, the principal approval mechanism for this deviation from requirements to provide true timely access would be a material modification to the plan's license. We have serious objections to the process as outlined. The material modification is an internal procedure that is not open to public comment or scrutiny. It would potentially provide plans that will not or cannot meet the timely access standard to evade their responsibility to do so.

7. Consideration of Plan Networks

Adequacy of network is one of the fundamental principles of the Knox-Keene Act. Plans that are unable to demonstrate adequate networks have been required to withdraw from geographic regions in which they are unable to provide adequate access to care or refused permission to add covered lives.

The current regulations in force establish standards based on ratios of enrollees to primary care physicians and all physicians. These have been stricken from the current regulatory language, and replaced with time-elapsed standards. Versions one and two of the Department's regulations contained specific time-elapsed standards based on type of practitioner, whether routine or urgent care, and the type of service sought. However in version three, the time-elapsed standards have been significantly weakened while the enrollee to provider ratios have also been eliminated. We believe the proposed regulation no longer can claim to meet the statutory mandate of requiring the Department to "consider the nature of the plan network."

8. Substantial Compliance in Provider Shortage Situations

In 1300.67.2.2 (e) (1) invites plans to propose variations for geographic areas in which there are shortages of particular types of providers. Health Access is opposed to the language providing an open-ended exemption from compliance with timely access standards in provider shortage situations. This is an exemption that could make meaningless all of the other requirements of these regulations and other basic provisions of the Knox-Keene Act.

This provision requires no explanation of the efforts the plan has undertaken to remedy the shortage of providers. Plans are able to rectify provider shortages by a variety of means including providing increased compensation to recruit and retain an adequate number and mix of providers, enhanced use of technology, utilization of out-of-network specialty consultations, among others. Provider shortages are largely a product of plan failure to compensate providers adequately and to treat them respectfully. It is said there is never a labor shortage, just a wage shortage or a working condition shortage. This section also does nothing to set any limits to an exemption, specify timelines or force other action, such as withdrawal from a geographic region where the plan is unable to provide timely access. If a plan cannot deliver timely access to the care it has promised the enrollee, it should not be permitted to do business in that geographic area.

We are particularly unsympathetic to those medical group administrators that have testified again and again over a period of years that they are unable to rectify provider shortages. Their failure to provide timely care and an adequate network merits

enforcement action. Consumers should not be put at risk of lack of care because of the incapacity of administrators.

Indeed the provision allowing an unlimited exemption from timeliness of access raises in our minds grave concerns as to whether the Department is meeting its statutory obligation to assure adequate networks by plans in their respective service areas.

We further note that California has successfully implemented standards for nursing care in both hospitals and nursing homes. In late 2003, regulations were finalized requiring nursing ratios in hospitals. In 2004, the hospital association attempted various maneuvers to delay or make meaningless these requirements. The various legal battles ended early in 2005. Attached is a chart from a 2007 report by the California HealthCare Foundation that demonstrates that nursing care increased from 7.5 hours per patient day in 2001 to 8.5 hours per patient day in 2005. In 2004, use of registry or temporary nursing staff increased significantly over historic levels but by 2005, use of registry had reverted to the more usual levels. This was done despite a shortage of registered nurses not only in California but across the country. Indeed Kaiser Permanente which implemented nursing ratios in advance of the requirement, increased wages and made other improvements in working conditions (such as allowing meal breaks!) was able to come into compliance even more quickly. If hospitals can obey the law, so can medical groups and health plans.

9. "Exemption" to Timely Access for Plans Offering Advanced Access

The exemption from adherence to timely access standards granted in (d) (4) and (5) is overly broad. If a plan does not provide advanced access, they must have systems and personnel in place to assure some basic tenets of timely access. If the plan does offer advanced access it is found to "demonstrate compliance" with this provision.

Plans, providers, and associations highlighted all of the difficulty they have in recruiting and retaining certain specialists in specific geographic areas. Consequently, we are skeptical that, without oversight, plans would be able to routinely deliver on these open-ended promises of advance access for all enrollees to all providers in all jurisdictions.

In addition, the preface to this solicitation of comments, the Department uses the term "safe harbor" for the plans who utilize this exemption. The connotation for this law enforcement term implies little or no oversight. With the difficulty expressed by plans and providers in providing timely access for certain types of care in certain locations, it would certainly be ill-advised to advertise that this provision would have very little review. It is certainly possible for plans to contend they provide advance access, and as a result, evade oversight of that aspect of their operation without penalty.

10. Timely Access to Care Should Be Reflected on OPA Report Card

AB2179 specifies that "the Department shall work with the patient advocate to assure that the quality of care report card incorporates information . . . regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care." There is no discussion of this statutory obligation in the regulatory language. We are skeptical that this requirement can or will be met with the Department's elimination of any concrete, standardized measurement of timely access performance. We also question how meaningful it would be to highlight plan or provider comparison data when each plan can establish its own, presumably weaker, "standards."

Timely access to care remains one of the principal complaints from consumers. We are committed to strong consumer protections that closely follow the original statute's intent and as a result, we recommend that the Department withdraw these proposed regulations, and work to strengthen the regulatory language. Health Access intends to work closely with the Department on the implementation, monitoring, and enforcement of this law, but we need better regulations in order to truly provide consumers the protections that they seek.

If you have questions or need further information, please contact Elizabeth Abbott at Health Access at (916) 497-0923 or Beth Capell, Capell & Associates, at (916) 497-0760.

Sincerely,

/s/
Anthony Wright
Executive Director

CC: Senator Sheila Kuehl, Chair, Senate Health Committee
Assemblymember Mervyn Dymally, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care
Suzanne Chammout, Chief, Regulation Development Division, DMHC

HEALTH ACCESS

August 22, 2008

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Braulio Montesino, Assistant Deputy Director

Re: Timely Access to Health Care Services on §1367.03

Dear Ms. Ehnes,

We appreciate being able to participate in the informal stakeholder process that you have initiated to implement, clarify, and make specific the provisions of § 1367.03 regarding the timely access to care regulation.

These regulations result from AB2179 (c. of 2002) by Assemblymember Rebecca Cohn. Health Access California, the statewide health care consumer advocacy coalition of more than 200 consumer, community and constituency organizations, was the original sponsor of this legislation. We continue to believe the lack of timely access is an indicator of serious, systemic problems that affect the delivery of health care in our state and the health outcomes of enrollees. If consumers do not have timely access to care, this often reflects broader problems such as lack of adequate provider panels, fiscal distress of a plan or provider, or shifts in the health care needs of a population. We have followed the long and often tortuous path that these regulations have taken since the law was passed and signed. We retain a keen interest in the outcome of the drafting of the regulation and expect the final language to reflect the landmark consumer protections envisioned in the law.

In light of the vocal opposition during the lengthy regulatory process and as reflected in numerous proposals, arguments, and justifications submitted to the Department, we can find no rationale whatsoever for DMHC to draft a regulation that proposes weak standards, allows multiple exceptions to those standards, or relies upon self-regulation by the plans. The force of the industry's opposition to timely access should dictate the need for the Department to write a regulation to provide a clear mandate, establish an unequivocal standard, undertake vigorous enforcement, and preserve greater protections for the enrollees as intended by the statute, rather than the reverse.

As a supplement to the chart that you requested from all stakeholders in this informal process, we have prepared this statement of principles that we believe should reflect the goals of the Department and govern the standards and language of the timely access regulation that is ultimately adopted. These principles should be:

1. **The Department's regulation should reflect specific and appropriate industry-wide, time-elapsed standards.**

We believe that specific time-elapsed standards established by the Department should be the only measurement of their stated goal of timely access to health care.

Since the enactment of the Knox-Keene Act, health care service plans have been obliged by §1367 (e) to assure that "all services shall be readily available at reasonable times to all enrollees". In developing the timely access program requirements, the Department reviewed the standards for timely access that the plans had filed with the Department for *three decades* and which both plans and providers had allegedly complied with for over thirty years. The regulations previously proposed by the Department were based on standards for timely access that were substantially consistent with those the plans say they imposed on themselves. If plans have failed to comply with their own standards, and years of complaints by consumers suggest this is the case, that is precisely what AB2179 and these regulations were intended to remedy. It is interesting to note that many plans and providers publicly testified that they were already providing exemplary timely access to care, in which case they should have no problem achieving and even exceeding these measurable time-elapsed standards.

2. **Timely access standards must apply to all health plans.**

AB2179 explicitly states that it applies to health care service plans and specialized healthcare plans. DMHC should not waive applicability for time-elapsed standards to specialized plans including dental, vision, acupuncture, chiropractic or EAP plans. While the Department heard considerable public testimony and alternate proposals complaining about the burden imposed on specialized plans, there is no such discretion or exception granted to the Department in the statute. Therefore, we can cite no such latitude granted by the legislature in the underlying statute.

§1367.03 (d) gives the Department no statutory authority to exempt plans from standards on timeliness of access. Indeed, §1367.03 (d) is quite clear that "if the department finds that health care service plans and health care providers are having difficulty in meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature". By this language, the Legislature made plain that the Department could

only return to the Legislature for further action and the Department lacks statutory authority to grant exemptions.

3. **Consumers should not have to make a choice between cultural and linguistic access to care and their right to timely access to care.**

We wish to object to some of the comments at the discussion at the introductory session that highlighted the alleged conflict between the Department's recent approval of the cultural and linguistic access to care regulation with this proposed regulation governing timely access. Health Access believes that low English proficient consumers should be entitled to timely access to care **and** that care should be delivered in a language that the patient can understand. The public testimony before the Department elicited numerous horrific examples of patients who did not speak English well who were denied care, had to wait hours to receive care, received inappropriate or even harmful care, were told their minor children or other untrained personnel were required to interpret for them in order to receive care, or were required to wait extraordinarily long intervals, and were then sent home.

We do not believe that consumers should have to choose between those rights or that providers should be permitted to make that choice for them. There are both federal and state statutes that would see that practice as discriminatory. We believe that there are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including technology assistance such as Video Medical Interpretation (VMI).

Further, Medi-Cal managed care plans have been required to meet language access standards from the inception of Medi-Cal managed care in 1993. Any failure on the part of Medi-Cal managed care plans or their contracting providers to provide adequate and timely access to linguistically appropriate services would represent a violation of longstanding public policy of the State of California and well-established contract standards. If Medi-Cal managed care plans or their contracting providers are reporting failures to comply with these requirements, the Department and its staff have the responsibility to promptly report those failures to Medi-Cal.

4. **All plans/providers should be required to meet standards regarding telephone triage after business hours.**

All health plans and/or all contracting providers should be required to provide prompt telephone service during business hours and telephone triage after hours. The need for health care does not occur only between 9:00 am and 5:00 pm, Monday through Friday. Timely access to care requires that consumers, who are not clinicians, have access to a health care professional who is trained to screen and refer them for emergency or

urgent care when appropriate or simply to assure them that they can safely wait until the morning to be seen. A recorded message provides no opportunity to evaluate the medical condition or communicate with the enrollee. A new mother with a baby with a high temperature or vomiting may not know whether her child needs care, a spouse with a partner with shortness of breath may not know what needs to be done, a family friend with an injury may not know whether they need to be seen urgently. These are precisely the kinds of cases AB2179 was intended to address.

We also take note that 85% of those who use emergency rooms have coverage of some sort, either Medi-Cal, Medicare or commercial insurance. Directing insured consumers to emergency rooms for triage of non-emergent conditions is wasteful and avoidable. These regulations should assure that consumers can get timely access to triage without being forced to use an emergency room.

If an enrollee does not have access at all times to a health professional that is licensed to triage so that an enrollee is forced by the lack of adequate network to be triaged in an emergency room, then the consumer should have no financial barriers to the use of emergency room care. Health plans cannot create financial barriers to the use of emergency room care and at the same time direct consumers to go to the emergency room for basic triage. This is an unacceptable Catch-22 where the consumer always loses, facing a choice between their money and their life.

We would prefer that plans and providers provide access to telephone triage 24 hours a day, seven days a week rather than sending consumers to overcrowded emergency rooms. We note that this 24 hour/7 days per week standard is one the Department itself meets at its own HMO Help hotline.

5. **Timely Access applies to plans and to their delegated groups, associations, and contractors.**

DMHC should include specific language in the regulation that plans must comply with timely access in those circumstances where the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities. While this language applies to all provisions of the Knox-Keene Act, it was specifically enacted in conjunction with the timely access provisions. Consequently, this provision on delegation and responsibility has the strongest possible statutory basis.

6. **DMHC should adopt meaningful standards for measuring enrollee satisfaction.**

In previous versions of the timely access regulations, the Department outlined requirements for quality assurance processes that include an "annual, statistically valid, enrollee satisfaction survey." We believe that to be a valid assessment of any genuine measure of enrollee satisfaction, the survey, including the questions asked, must be a publicly available document.

DMHC has stipulated in the past that plans that use the CAHPS or ECHO survey instruments in connection with certification by NCQA may meet the requirements of this subsection by including appropriate supplemental questions as approved by the Department. The CAHPS survey is not a publicly available document; it is instead the creation of a private industry entity, available only at considerable cost, and not subject to either the open meetings law or the public records act and would not meet that standard.

7. **Plans must be required to afford timely access even in areas where there are recognized shortages of certain providers.**

If the Department plans to allow plans to propose variations for geographic areas in which there are shortages of particular types of providers, we believe any approved exception must meet requirements in terms of rationale, duration, documentation, and remedies undertaken or proposed. Specifically, any request for an exception must be accompanied by a corrective action plan for remedying the failure of the plan to comply with the requirements.

Health Access is opposed to any language providing an open-ended exemption from compliance with timely access standards in so-called provider shortage situations. This is an exemption that could make meaningless all of the other requirements of these regulations and other basic provisions of the Knox-Keene Act.

Plans are able to rectify provider shortages by a variety of means including providing increased compensation to recruit and retain an adequate number and mix of providers, enhanced use of technology, utilization of out-of-network specialty consultations, among others. Provider shortages are largely a product of plan failure to compensate providers adequately and to treat them respectfully. It is said there is never a labor shortage, just a wage shortage or a working condition shortage. We believe DMHC must also set limits to any exemption, specify timelines or force other action, such as withdrawal from a geographic region where the plan is unable to provide timely access. If a plan cannot deliver timely access to the care it has promised the enrollee, it should not be permitted to do business in that geographic area.

We are particularly unsympathetic to those medical group administrators that have testified repeatedly over a period of years and are restating the argument in this stakeholder process that they are unable to rectify provider shortages. Their failure to

provide timely care and an adequate network merits enforcement action. Consumers should not be put at risk of lack of care because of the incapacity of administrators.

In an analogous situation, California has successfully implemented standards for nursing care in both hospitals and nursing homes. In late 2003, regulations were finalized requiring nursing ratios in hospitals. In 2004, the hospital association attempted various maneuvers to delay or make meaningless these requirements. The various legal battles ended early in 2005. The California HealthCare Foundation reported in 2007 that nursing care increased from 7.5 hours per patient day in 2001 to 8.5 hours per patient day in 2005. In 2004, use of registry or temporary nursing staff increased significantly over historic levels but by 2005, use of registry had reverted to the more usual levels. This was done despite a shortage of registered nurses not only in California but also across the country. Indeed Kaiser Permanente which implemented nursing ratios in advance of the requirement, increased wages and made other improvements in working conditions (such as allowing meal breaks!) was able to come into compliance even more quickly. If hospitals can obey the law, so can medical groups and health plans.

Adequacy of network is one of the fundamental principles of the Knox-Keene Act. Plans that are unable to demonstrate adequate networks have been required to withdraw from geographic regions in which they are unable to provide adequate access to care or refused permission to add covered lives.

8. Exceptions should be allowed only for true health care emergencies.

Existing law, specifically Business and Professions Code Section 900, defines a health care emergency as one in "emergency overwhelms the response capabilities of California health care practitioners and only upon the request of the Director of the Emergency Medical Services Authority". This section and Government Code Section 8558 (b) which it references provides guidance so that true health emergencies (bioterrorism, major earthquakes, pandemics, etc) are distinguished from emergencies that do not affect health capacity (e. g. light brown apple moth).

Health Access California would not oppose an exemption for emergencies that meet the standard of Business and Professions Code Section 900.

Workforce shortages are not health care emergencies: those who invoke workforce shortages as an excuse for denying consumers timely access to care remind us of the individual who upon murdering his parents threw himself on the mercy of the court as an orphan.

9. **There should be no "exemption" to timely access for plans offering advanced access, particularly without Departmental oversight.**

Health Access opposes any exemption from adherence to timely access standards that is overly broad. If a plan does not provide advanced access, they must have systems and personnel in place to assure some basic tenets of timely access. If the Department does permit plans to meet the timely access requirement by offering advanced access, the plans should be subject to the same kind of compliance requirements and oversight that plans are subject to who attempt to meet timely access without such an exemption.

In previous public testimony and throughout this stakeholder process, plans, providers, and associations have highlighted all of the difficulty they have in recruiting and retaining certain specialists in specific geographic areas. We object to the tenet previously proposed by the Department that whenever a plan is permitted to offer "same day" or "advanced" access to care, it is found to "demonstrate compliance" with the timely access provision. We are skeptical that, without oversight, plans would be able routinely to deliver on these open-ended promises of advance access for all enrollees to all providers in all jurisdictions.

In addition, the Department has used the term "safe harbor" for the plans who would utilize this exemption. The connotation for this law enforcement term implies little or no oversight. With the difficulty expressed by plans and providers in providing timely access for certain types of care in certain locations, it would be ill advised to advertise that this provision would have very little review. It would be a betrayal of the Department's commitment to consumer protection to permit plans to contend they provide advance access, and as a result, evade oversight of that aspect of their operation without penalty.

10. **Any alternative standards must meet specific standards for a limited time period and be reviewed using a public process.**

If the Department outlines a method for plans to propose alternatives to the timely access standards specified, it should include requirements as to the conditions, duration and actions undertaken by the plan.

DMHC should not grant permission to a plan to adopt an alternative, more lenient standard with the Department's concurrence that would last for years.

The Department should evaluate any alternative standard as to whether the proposed alternative standard is "more appropriate". Since all too often plans and providers translate "more appropriate" as more convenient for the plan or the provider, ignoring the needs of the consumer; this should specify that the proposed alternative is more appropriate <u>for the consumer.</u>

In addition, historically the principal approval mechanism for this deviation from requirements to provide true timely access would be a material modification to the plan's license. We have serious objections to that process. The material modification is an internal procedure that is not open to public comment or scrutiny. It would potentially provide plans that will not or cannot meet the timely access standard to evade their responsibility to do so.

§1367.03 (d) gives the Department no statutory authority to exempt plans from standards on timeliness of access. Indeed, it is quite clear that "if the department finds that health care service plans and health care providers are having difficulty in meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature". By this language, the Legislature made plain that the department could only return to the Legislature for further action and the department lacks statutory authority to grant exemptions due to provider shortages.

11. DMHC's regulation should not restrict litigation against a plan caused by its denial, delay or modification of a health care service if it resulted in substantial harm.

The Legislature in its deliberations could have added such a provision restricting litigation and did not do so. The Legislature has expressly permitted litigation against health plans (SB21 Figueroa, c. 536 of 1999) to allow litigation against health care service plans for the failure to exercise ordinary care. The Legislature that enacted AB2179 in 2001 was well aware of the action it had taken in 1999. Any language regarding a prohibition of individual cause of action has no statutory basis and indeed its inclusion contradicts the legislative history.

12. Timely access to care should be reflected on OPA Report Card.

AB2179 specifies that "the Department shall work with the patient advocate to assure that the quality of care report card incorporates information . . . regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care." There should be a discussion of this statutory obligation in the regulatory language. We believe this requirement would reinforce the importance of requiring time-elapsed standards in order to make the comparison data meaningful among various plans. There is no value in inviting comparisons by purchasers, advocates, or consumers when the data reflected is not concrete, timely, data-specific, uniform, accessible, and applies to the industry as a whole.

Timely access to care remains one of the principal complaints from consumers. We are committed to strong consumer protections that closely follow the original statute's intent. Health Access is hopeful that this process will conclude expeditiously. We intend to work closely with the Department on the implementation, monitoring, and enforcement of this law to provide consumers the protections that they seek.

If you have questions or need further information, please contact Elizabeth Abbott at Health Access at (916) 497-0923 or Beth Capell, Capell & Associates, at (916) 497-0760.

Sincerely,

Anthony Wright
Executive Director

CC:

Cindy Ehnes, Director, Department of Managed Health Care
Ed Heidig, Principal Deputy, Department of Managed Health Care
Suzanne Chammout, Chief, Regulation Development Division, DMHC

HEALTH ACCESS CALIFORNIA

November 25, 2008

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Emilie Alvarez, Regulations Coordinator

Re: Timely Access to Health Care Services on §1367.03

Dear Ms. Ehnes,

We appreciate being able to participate in the informal stakeholder process that you initiated based on AB2179 (c. of 2002) by Assemblymember Rebecca Cohn.

Health Access California, the statewide health care consumer advocacy coalition of more than 200 consumer, community and constituency organizations, was the original sponsor of this legislation. We continue to believe the lack of timely access is an indicator of serious, systemic problems that affect the delivery of health care in our state and the health outcomes of enrollees. If consumers do not have timely access to care, this often reflects broader problems such as lack of adequate provider panels, fiscal distress of a plan or provider, or shifts in the health care needs of a population. We have followed the long and often tortuous path that these regulations have taken since the law was passed and signed. We retain a keen interest in the outcome of the drafting of the regulation and believe your final version of the language should reflect the landmark consumer protections envisioned in the law.

Our goal is for the Department to craft the regulation to provide a clear mandate, establish an unequivocal standard, undertake vigorous enforcement, and provide greater protections for the enrollees as intended by the statute. We applaud the Department's return to regulations based on time-elapsed standards. These are the only measure that meets the statutory requirement. While we generally support the language of the regulation put forward by the Department, we offer the following comments to strengthen the regulatory requirements and oversight by DMHC:

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1. **Timely access standards must apply to all health plans.**

AB2179 explicitly states that it applies to health care service plans and specialized health care plans. DMHC should not waive applicability for time-elapsed standards to specialized plans including dental, vision, acupuncture, chiropractic or EAP plans. While the Department heard considerable public testimony and alternate proposals complaining about the burden imposed on specialized plans, there is no such discretion or exception granted to the Department in the statute. Therefore, we can cite no such latitude granted by the legislature in the underlying statute. The Legislature made plain that the Department could only return to the Legislature for such further action and the Department lacks statutory authority to grant these exemptions.

The language in §1300.67.2.2 (b) states that dental, vision, chiropractic, acupuncture, and employee assistance programs shall comply with sections (c) (1), (3), (4), (6), (7), (9) and (10). § (c) (9) describes the requirements for dental, vision, chiropractic, and acupuncture plans to comply with telephone triage. It states that during non-business hours these specialized plans must offer an answering service, telephone answering machine, or enable enrollees to obtain urgent or emergency care. While this section deals with the telephone triage issue, it does not comply with the requirement for consumers to be able to secure timely appointments and referrals. Language addressing this issue should be added or the specific section should be revised to reflect that the provisions of (c) (5) should apply to all plans. We are willing to consider alternative time-elapsed standards for these plans, but the DMHC lacks statutory authority to fail to give time-elapsed standards to specialized plans.

2. **DMHC's regulation should not restrict litigation against a plan caused by its denial, delay or modification of a health care service if it resulted in substantial harm.**

The Legislature in its deliberations could have added such a provision restricting litigation and did not do so. The Legislature has expressly permitted litigation against health plans. SB21 Figueroa, c. 536 of 1999) allows litigation against health care service plans for the failure to exercise ordinary care. Lack of timely access can cause actual harm. Any language regarding a prohibition of individual cause of action has no statutory basis and indeed its inclusion contradicts the legislative history.

3. **Definitions should conform to statutory language and intent.**

§1300.67.2.2 (b) (2) "Ancillary services" should be revised to read "means all health care provider specialties except medical doctors, doctors of osteopathy, nurse practitioners, certified nurse midwives, and physician assistants." Specifically "medical assistants" should not be included because they are required to have a minimum of 10 clock hours of training by law.

4. **Consumers should not have to make a choice between cultural and linguistic access to care and their right to timely access to care.**

Health Access believes that low English proficient consumers should be entitled to timely access to care **and** that care should be delivered in a language that the patient can understand. We do not believe that consumers should have to choose between those rights or that providers should be permitted to make that choice for them. We believe that provision of language services in scheduling or receiving care should not produce additional wait times. There are both federal and state statutes that would see that practice as discriminatory. We believe that there are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including technology assistance such as Video Medical Interpretation (VMI).

We further believe that Limited English Proficient (LEP) enrollees should be oversampled in annual surveys to ensure that the needs and experiences of vulnerable populations are taken into account. These LEP populations and communities of color are among the least likely to complain. Survey instruments should be translated into the plan's threshold languages to be sure to capture the relevant data from these consumers.

5. **Systems, policies, and procedures of quality assurance must actually demonstrate appropriate access to care.**

§1300.67.2.2 (c) (5) (I) states that "a plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes, and systems providing advanced access to primary care appointments. . . ." We do not believe this standard can be considered to be met by a surface process measurement. We believe that a plan may only demonstrate timely access to care if it is actually providing measurable timely access to care. In other words, it is not sufficient to establish "standards, processes, and systems" unless true advanced access to care is regularly provided. The language used in this section should not permit the substitution of process measures in lieu of actual verified access to care.

Similarly, the language in §1300.67.2.2 (3) (E) should reflect that the verification of the advanced access programs as reported are sufficient to assure timely access to primary care consistent with the standards set forth in subsection (c).

6. **Flexibility in appointment times provided in 1300.67.2.2 (d) (2) must be governed by clinical appropriateness and professionally recognized standards of practice.**

The language in this section describes the requirements for continuity of care and referral systems if a contracted provider is unable to deliver timely access to care. The Department proposes giving further latitude if the enrollee prefers to wait for a later appointment from a specific contracted provider. We believe that further delays to

accommodate the patient's preference must always take into account whether the delay is **clinically appropriate and consistent with professionally recognized standards of practice** and that stipulation must be incorporated into the language of this exception. Consumers are not clinicians and cannot be expected to properly gauge the clinical outcome of any delays in order to wait for an appointment with a preferred provider. This exception to timely access to care mirrors the circumstances in the Utterback decision that resulted in the largest fine levied against a health plan for the failure to deliver care within critical time constraints.

7. **Each plan's annual survey should measure compliance in each of the plan's service areas.**

The language in §1360.67.2.2. (d) (3) (B) and (C) should be revised to reflect that each of the annual enrollee and provider surveys should be conducted in accordance with valid and reliable survey methodology, using a stratified random sample to test for compliance in each of the service areas of the plan, and designed to ascertain compliance with the standards set forth at subsection (c).

8. **Any alternative standards must meet specific standards for a limited time period and be reviewed using a public process.**

In 1300.67.2.2(g) the Department outlines a method for plans to propose alternatives to the timely access standards specified. Health Access is opposed to any language providing an open-ended exemption from compliance with timely access standards in so-called provider shortage situations. This is an exemption that could make meaningless all of the other requirements of these regulations and other basic provisions of the Knox-Keene Act.

The Department proposes to utilize the material modification procedure for the approval process. We have serious objections to that process as follows:

- The material modification as it stands is an internal procedure that is not open to public comment or scrutiny. It would potentially provide plans that will not or cannot meet the timely access standard to evade their responsibility to do so. We urge the Department to have an open process to review deviations from the timely access standards; at the minimum the request for the material modification of their license should be posted on the Department's website upon receipt from the plan. The Department should solicit comments from enrollees, purchasers, advocates and the public before ruling on the plan's request.
- The Department should evaluate any alternative standard as to whether the proposed alternative standard is "more appropriate". Since all too often plans and providers translate "more appropriate" as more convenient for the plan or the provider, ignoring the needs of the consumer; this should specify that the proposed alternative is more appropriate for the consumer.

- Any approved exception must meet requirements in terms of rationale, duration, documentation, and remedies undertaken or proposed. Specifically, such a request for an exception generally must be accompanied by a corrective action plan for remedying the failure of the plan to comply with the requirements. The regulation should state this explicitly.
- In approving or disapproving a plan's proposed alternative timely access standards, the Department should consider all relevant factions, including but not limited to the factors set forth in subsection (d) and (e) of section 1367.03 of the Act, section 1342 of the Act, and subsection (c) of section 1300.67.2.1. The Department should take special note of any public comment received by the Department through the public notice process they establish.
- DMHC must also set limits to any exemption, specify timelines or force other action, such as withdrawal from a geographic region where the plan is unable to provide timely access. If a plan cannot deliver timely access to the care it has promised the enrollee, it should not be permitted to do business in that geographic area.
- The Department should approach review of these requests for alternative standards as a short-term transition to conform to the Department's established time-elapsed standards. Any interim standards should be of limited duration, include stringent conditions, and require the plan to take actions to reach timely access performance goals. DMHC should not grant permission to a plan to adopt an alternative, more lenient or ill-defined standard that would last for years.
- With respect to new technologies, we believe that the language of the regulation also permits consumers to secure appointments and obtain consultations with health care professionals using technology and communication modes that are not in common use today.

9. Plan compliance with timely access standards should be measured in their annual report to the Department in smaller geographic units than counties in the plan's service area and should be mapped to the plan's enrollees.

The proposed language in §1300.67.2.2(h) requires the plan to report to the Department on an annual basis regarding their compliance for the preceding year. The regulation requires the plan to "separately report for each of the plan's contracted provider groups located in each county of the plan's service area."

We believe this is demonstrably too large a geographic unit to provide meaningful data to the Department for them to judge plan compliance. We recommend DMHC use the "Medical Service Study Area (MSSA)" geographic unit as developed by California's Office of State Health Planning and Development (OSHPD) based on OSHPD and census data.

It would be much clearer for plans and the Department to track compliance using a well-established smaller geographic unit such as the MSSA. For example, using county-wide data for Los Angeles County could easily mask medical shortage and underserved areas within such a high density population center which contain multiple smaller cities,

ethnic neighborhoods, and such a broad divergence of socio-economic, racial, and transportation patterns within the county. It would be similarly difficult to assess compliance county-wide in San Bernardino county (the largest county in the continental U.S., roughly the size of the entire state of Rhode Island) with its population centers in the Inland Empire as opposed to the more sparsely populated portion of the county in the high desert.

In addition, each plan should submit with their report a map or other diagrammatic method for depicting the geographic distribution of the plan's enrollees, overlaid on the geographic distribution of the plan's provider network. This depiction of the plan's members superimposed on the plan's provider network would graphically highlight any misalignment in parts of the geographic service area where the plan should be concentrating their recruitment, retention, and alternative service model efforts.

10. The Department should evaluate a plan's compliance with timely access including what might be construed as efforts to evade the intent of the law.

The Department should be particularly alert to any efforts by the plans to appear to offer service within a reasonable time frame, but which offer merely token adherence to the law. These include, but are not limited to:

- Referring enrollees to providers who are not appropriate for an enrollee's condition,
- Referring enrollees to providers whose level of training and experience is not appropriate for the level of care indicated,
- Referring enrollees to providers who are no longer accepting new patients,
- Referring enrollees who do not have available appointment slots within reasonable time constraints,
- Referring enrollees to providers whose business location is beyond a reasonable travel distance for the consumer (except with the enrollee's explicit consent),
- Referring enrollees to providers who do not have sufficient support staff to schedule, confirm, reschedule, promptly return phone calls, report back to the referring physician, or perform other administrative functions to make that referral a reasonable option,
- Referring enrollees to providers who charge the patient a higher share of cost and fees than would normally be incurred by the enrollee receives services in-network. The consumer who is forced to go out of network because of the plan's lack of providers should not suffer significant financial consequences.

11. If DMHC should incorporate survey methodology, they must adopt meaningful standards for measuring enrollee satisfaction.

The Department outlined requirements for quality assurance processes that include an "annual, statistically valid, enrollee satisfaction survey" in previous versions of the timely access regulations. During the informal stakeholders' discussions, plans, providers,

and associations argued in favor of surveys to measure timely access to care. We believe that to be a valid assessment of any genuine measure of enrollee satisfaction, the survey, including the questions asked, must be a publicly available document.

DMHC has stipulated in the past that plans that use the CAHPS or ECHO survey instruments in connection with certification by NCQA may meet the requirements of this subsection by including appropriate supplemental questions as approved by the Department. The CAHPS survey is not a publicly available document; it is instead the creation of a private industry entity, available only at considerable cost, and not subject to either the open meetings law or the public records act and would not meet any standard or serve as a substitute measure for timely access.

12. Timely access to care should be reflected on OPA Report Card.

AB2179 specifies that "the Department shall work with the patient advocate to assure that the quality of care report card incorporates information . . . regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care." There should be a discussion of this statutory obligation in the regulatory language. We believe this requirement would reinforce the importance of requiring time-elapsed standards in order to make the comparison data meaningful among various plans. There is no value in inviting comparisons by purchasers, advocates, or consumers when the data reflected is not concrete, timely, data-specific, uniform, accessible, and applies to the industry as a whole.

Timely access to care remains one of the principal complaints from consumers. We are committed to strong consumer protections that closely follow the original statute's intent. Health Access is hopeful that this process will conclude expeditiously. We intend to work closely with the Department on the implementation, monitoring, and enforcement of this law to provide consumers the protections that they seek.

If you have questions or need further information, please contact Elizabeth Abbott at Health Access at (916) 497-0923 or Beth Capell, Capell & Associates, at (916) 497-0760.

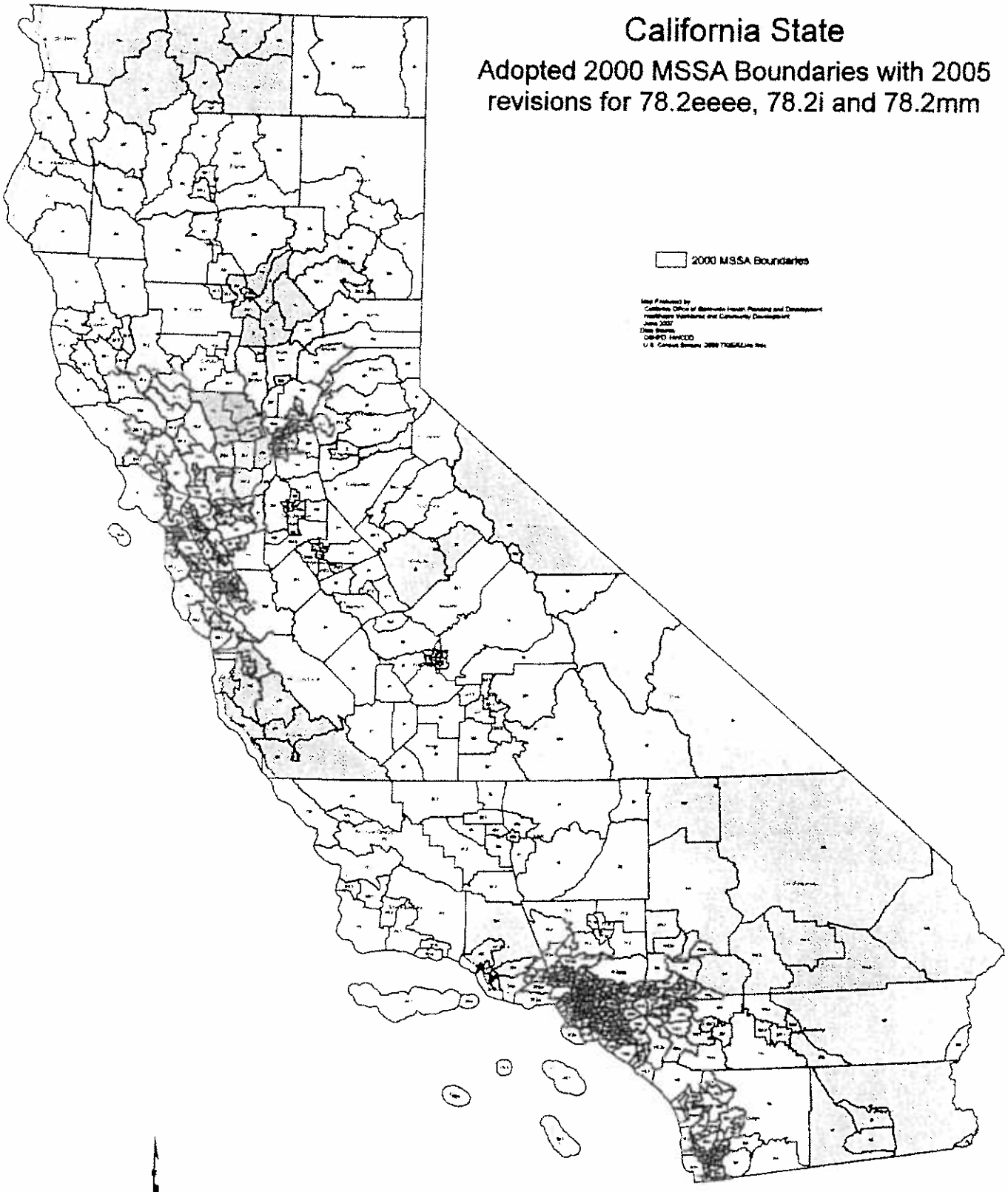
Sincerely,

Anthony Wright
Executive Director

CC: The Honorable David Jones, Chair, Assembly Health
Richard Figueroa, Office of the Governor
Cindy Ehnes, Director, Department of Managed Health Care
Ed Heidig, Principal Deputy, DMHC
Suzanne Chammout, Chief, Regulation Development Division, DMHC
Braulio Montesino, Assistant Deputy Director, DMHC
Richard Martin, Deputy Director, Financial Solvency Standards Board, DMHC

California State

Adopted 2000 MSSA Boundaries with 2005 revisions for 78.2eeee, 78.2i and 78.2mm



February 23, 2009

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Suzanne Chammout, Chief, Regulations Development Division
Emilie Alvarez, Regulations Coordinator

Re: Timely Access to Non-Emergency Health Care Services:
Control No. 2008-1579

Dear Ms. Ehnes,

Health Access California, the statewide health care consumer advocacy coalition of more than 100 consumer, community and constituency organizations, was the original sponsor of AB2179 (c. 797 of 2002), authored by then-Assemblymember Rebecca Cohn. The proposed regulations seek to implement that legislation.

Health Access generally supports the proposed regulations as consistent with statutory authority but offers specific changes to some provisions of the proposed regulations to assure that the intent of the Legislature to assure timely access is met.

A. Overall Comments

1. Timely Access is Fundamental to Knox-Keene Act

Timeliness of access to care is fundamental to the Knox-Keene Act: from its enactment in 1975, health care service plans have been obliged to provide timely access to care under Sec. 1367 (e).

For almost thirty-five years now, in order to comply with that provision of law, each health care service plan has filed a plan for providing timely access to care. In 2002, the Department of Managed Health Care surveyed the major plans and found that in every instance, plans had been filing access standards that relied on the time elapsed between a consumer seeking care and obtaining it. (See Attachment A). For example, Aetna in its access standards said that care would be provided within three days for symptomatic, non-urgent acute complaints and within seven days for routine care while Blue Shield said that routine, non-urgent symptomatic care would be provided within seven days and Healthnet said that non-urgent care would be provided within seven working days. The access

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standards that plans filed tended to be consistent across plans and are generally consistent with the standards proposed in these regulations.

Unfortunately, while health plans filed these self-imposed standards, consumer after consumer reported that they were unable to obtain timely access to care. Among those consumers who failed to obtain timely access to care were many legislators, including not only those who authored legislation in this area but those who spoke to its importance during the legislative process. Legislation to correct this was first introduced in 1997 (AB497 by Assemblymember Scott Wildman) and was enacted in 2002 (AB2179, c. 797 of 2002).

2. Legislative Intent:

In enacting AB2179, the Legislature declared in Section 1:

> *SECTION 1. It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers have timely access to health care. The Legislature finds and declares that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population. It is the further intent of the Legislature in enacting this section that the department shall incorporate the standards developed under this section in licensing, survey, enforcement, and other processes intended to protect the consumer.*

As the Legislature stated and Governor Gray Davis acknowledged in signing AB2179 with that statement of legislative intent, lack of timely access to non-emergency health care services indicates serious, systemic problems that affect the delivery of health care in our state and the health outcomes of enrollees. If consumers covered by a health plan do not have timely access to care, the lack of timely access often reflects broader problems, including lack of adequate provider panels, fiscal distress of a plan or provider, or shifts in the health care needs of a population.

3. Time-Elapsed Standards

The law states that DMHC may adopt standards other than time-elapsed standards if the department is able to demonstrate why another standard is more appropriate.

In the administrative process of developing these regulations which dates back to hearings before the department's advisory committee in 2002, concurrent with the legislative process, no organization or individual has proposed any standard other than time-elapsed standards.

As the department notes in its statement of reasons, same-day access is a time-elapsed standard. Same-day access provides that a consumer can obtain routine, non-urgent care on the same day that the consumer seeks care. Same day access is simply

a briefer time period than the time-elapsed standard of seven days for routine care used by most major health plans.

In all of the debate, discussions, hearings, meetings, workgroups, submissions, and other expressions of views, virtually the only standard for timely access that has been proposed has been time-elapsed standards, including same-day access. While there has been a great deal of discussion and debate, very little of it has offered alternatives that complied with the plain language of the statute.

One approach that has been suggested is to allow each physician to decide for each patient what would constitute timely access. This is not a standard. It would not "ensure that enrollees have access to needed health care services in a timely manner" (S.1367.03 (a)) unless accompanied by numerous other protections for consumers. It does not correct what the Legislature intended to correct. It would not permit the Department to monitor compliance.

If there is no common standard that applies to both providers and plans, then consumers will not know what to expect. Time-elapsed standards create an expectation of what is appropriate that can be understood by consumers, providers and plans alike. Time-elapsed standard also help strengthen compliance and enforcement because consumers can know when to report a problem, and when a delay is still within reason. The lack of time-elapsed standards undermines enforceability.

While the proposed regulation package correctly asserts the primacy of clinical judgment (see statement of reasons pp.3-4 and proposed 1300.67.2.2 (c) (1)), it creates time-elapsed standards that provide an outer bound as to when appointments should be offered. We recognize that the department allows providers and plans to offer appointments at a time later than that required under the proposed time elapsed standard if the provider determines and documents that the later time will not have a detrimental impact on the enrollee. This allows a provider to exercise their clinical judgment so long as that provider can document that harm to the enrollee is not expected from a delay.

Time-elapsed standards should serve as a minimum with clinicians able to provide more timely care if that is clinically necessary.

4. Economic Impact of Lack of Timely Access

Lack of timely access to care can have significant economic impacts. While we are not aware of independent peer-reviewed research specifically on point, we offer the following observations which are supported by peer-reviewed research:

First, lack of timely access can cost enrollees lost work-days and lost school-days. This is particularly true if lack of timely access results in avoidable emergency room visits. Even delays in timely access that do not result in avoidable emergency room visits but that unnecessarily impair health so that the enrollee is unable to engage in work or school may result in lost work-days and lost school-days that would otherwise be

productive days. One of the important reasons to have health coverage is to be able to engage in activities of normal living, including work and school. Health coverage that does not provide timely access means that consumers miss work or school due to avoidable emergency room visits or treatable conditions. Lost productivity is a social cost of failure to provide timely access.

Second, several studies have documented that the increase in emergency room care in California is due to an increase in utilization by persons "with" coverage. (Please see Attachments B and C). Lack of timely access for triage, urgent care, primary care and specialty care contribute to avoidable emergency room use. We take note of the requirement on waiting times to speak to a physician or other qualified health professional in AB2179 and the proposed regulation requiring triage within 10 minutes by a health professional. This requirement for timely triage combined with the requirement for timely urgent care ought to induce system change that will maximize care in the outpatient setting, minimizing avoidable emergency room use.

Third, a substantial body of academic literature, commencing with the work of Dr. John E. Wennberg and the Dartmouth Atlas, indicates that hospitalization for ambulatory-sensitive conditions is a major cost driver in health care. Treatment of such ambulatory-sensitive conditions in an outpatient setting reduces health care costs directly. Lack of timely access impedes appropriate management of care: put simply, people get care in the hospital and the emergency room instead of the doctor's office and it costs more. Assuring timely access to clinically appropriate care can help to reduce the cost of care for insured populations.

B. Comments on Specific Provisions and Language

In this section, Health Access California offers comments on specific provisions and language of the proposed regulations.

1. Urgent Care: 48 hours is a long time to wait

One of the objectives of the timely access regulations is to reduce inappropriate emergency room use by those with health plan coverage. Both the provisions for triage and for urgent care should have this effect.

However, 48 hours is a long time to wait for care that meets the standard of urgent care as defined in S.1367.01 (h) (2) as serious and imminent threat to the health of an enrollee.

We oppose the provision that permits urgent care to be delayed as long as 96 hours if priority authorization is required. We think this will cause confusion for consumers and providers about what the standard is. We suggest that (c) (5) (g) already permits a longer waiting period for urgent care if the provider determines and documents that the longer wait will not have a detrimental impact on the health of the enrollee.

2. **Same Day Access: Systems, policies, and procedures of quality assurance must actually demonstrate appropriate access to care.**

With respect to monitoring of same-day access, the statement of reasons lacks clarity: because of this, we fear that the proposed regulation will lack clarity in operation.

Specifically, the statement of reasons on p. 2 and p.7 states that the regulation

> Establishes a "safe harbor" provision for time-elapsed standards for primary care services. Specifically, if "advanced access" scheduling for primary care services is provided, the Department will consider that to be in compliance with the time-elapsed standards for primary care appointments.

However, on p. 11 of the statement of reasons, the department states that

- Subsection (d) (3) (e) specifies that plans must verify the "advanced access" programs reported by that provider groups and independent practice associations (IPAs). This provision is framed in terms of a performance standard that permits plans sufficient operational flexibility to develop mechanisms for *confirming* that these provider groups and IPAs are scheduling appointments consistent with the definition of advanced access in subsection (b) (1). *(emphasis added)*

The use of the term "safe harbor" in quotation marks lacks clarity because the term has specific meaning: we are unable to determine whether in this instance it has that meaning or some other meaning as suggested by the quotation marks.

Health Access does not oppose same-day access so long as consumers can actually get the primary care they need on the same day. The statement of reasons on p. 11 indicates that the enforcement mechanism in (d) (3) (E) is intended to confirm that consumers are getting care on the same day. Unfortunately, the language of the proposed regulation is not clear on this point. For that reason, we suggest the following change:

> (d) (3) (E) Verifying the Advanced Access programs reported by contracted providers, medical groups and independent practice associations <u>to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b) (1).</u>

3. **Flexibility in appointment times and triage provided in 1300.67.2.2 (c) (5) and (9) is appropriately governed by clinical appropriateness and professionally recognized standards of practice.**

We commend the Department for the proposed language of the regulation that permits delays only if clinically appropriate and consistent with professionally recognized standards of practice. Consumers are not clinicians and cannot be expected to properly gauge the clinical outcome of any delays in order to wait for an appointment with a preferred provider. We also commend the Department for the requirement that the decision to delay care be documented and that it include a determination that delay will not have a detrimental impact on the health of the enrollee. The Department has taken strong action to protect consumers from lack of timely access to care in the <u>Utterback</u>

decision that resulted in the largest fine levied against a health plan for the failure to deliver care in a timely and clinically appropriate manner.

4. **Consumers should not have to make a choice between cultural and linguistic access to care and their right to timely access to care.**

Health Access believes that low English proficient consumers should be entitled to timely access to care and that care should be delivered in a language that the patient can understand. We do not believe that consumers should have to choose between those rights or that providers should be permitted to make that choice for them.

Provision of language services in scheduling or receiving care should not produce additional wait times. There are both federal and state statutes that would see that practice as discriminatory. There are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including technology assistance such as Video Medical Interpretation (VMI). Health Access has years of experience working with various public hospital systems to implement language access, through both remote voice and video, so that an interpreter is available within a minute of a clinical visit.

For these reasons, we support the proposed regulation in (c) (4) which requires that interpreter services as required under state law and regulation be coordinated with scheduled appointments.

In order to assure compliance with this requirement, Limited English Proficient (LEP) enrollees should be oversampled in annual surveys to ensure that the needs and experiences of vulnerable populations are taken into account. These LEP populations and communities of color are among the least likely to complain. Survey instruments should be translated into the plan's threshold languages to be sure to capture the relevant data from these consumers. We offer specific amendment on this point below in the section on geographic access.

5. **Any alternative standards should be more appropriate for enrollees and be subject to public disclosure**

In 1300.67.2.2(g) the Department outlines a method for plans to propose alternatives to the timely access standards specified. Health Access has previously expressed concern that an exemption from the timely access standards could make meaningless all of the other requirements of these regulations and other basic provisions of the Knox-Keene Act.

The Department proposes to utilize the material modification procedure for the approval process. This is not a public process: there is no public notice, no public review, and no public comment. The department also proposed to allow indefinite extensions of alternative standards.

We recognize that in the proposed regulations the Department is trying to balance the need for flexibility with the obligation to protect enrollees. We commend the Department for the elements of the proposed regulation that require:

- ✓ An explanation of the clinical and operational reasons that a plan is requesting an alternative standard
- ✓ A requirement that the plan provide scientifically valid evidence based on reliable and verifiable data demonstrating the proposed alternative is consistent with professionally recognized standards of practice
- ✓ A description of the expected impact on clinical outcomes and on contracted health providers.
- ✓ Annual updates, including updated documentation of the continued need

Health Access offers the following specific amendments to (g):

(1) An explanation of the plan's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, *on access for enrollees,* and on contracted providers.

(2) The burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate *for the enrollees* than time elapsed standards. Plans that have received approval for an alternative standard shall file, on an annual basis, an amendment requesting approval for continued use of the alternative standard, and providing updated information and documentation to substantiate the continued need for the alternative standard. *The plan shall also document efforts to come into compliance with the standards in (c) and the anticipated date by which the plan intends to come into compliance.*

(3) In approving or disapproving a plan's proposed alternative timely access standards the Department may consider all relevant factors, including but not limited to the factors set forth in subsections (d) and (e) of Section 1367.03 of the Act and subsection (c) of section 1300.67.2.1. *The Department may impose a corrective action plan to assure compliance with the Act.*

(4) *The Department shall post to its website the information provided by any plan in seeking such a material modification and any annual filing.*

With respect to new technologies, we believe that the language of the regulation also permits consumers to secure appointments and obtain consultations with health care professionals using technology and communication modes that are not in common use today.

6. Timely access standards must apply to all health plans.

AB2179 explicitly states that it applies to health care service plans and specialized health care plans. The statute does not provide an exemption for specialized plans from complying with any standards that are established. Nothing in the law permits the

department to exempt specialized plans from (d) quality assurance, (e) enrollee disclosure, (f) contracting relationships, or (h) filing and reporting requirement.

The statute requires that time-elapsed standards apply to specialized plans including dental, vision, acupuncture, chiropractic and mental health plans. We support the provisions of the proposed regulations that apply to specialized plans and we oppose the exemption of other requirements on specialized plans. The Legislature made plain that the Department lacks statutory authority to grant exemptions for specialized plans.

We commend the Department for taking particular care to address mental health carve-outs and defer to our colleagues in the mental health community with respect to the specifics. With respect to dental plans, we find it appropriate that the standards are specific to those plans.

7. The Regulations Must Apply to Medi-Cal and Healthy Families Plans

When Medi-Cal managed care was implemented and when Healthy Families was enacted, both programs were presented as providing improvements in care because care would be provided or arranged by Knox-Keene licensed health plans. Again and again consumers who opposed Medi-Cal managed care and the "private insurance model" for S-CHIP implementation were told that the consumer protections in the Knox-Keene Act would apply.

Health Access strongly opposes creating a separate tier of consumer protections for Medi-Cal and Healthy Families enrollees. If mandatory Medi-Cal managed care is failing, then we should consider repealing it and returning to fee-for-service Medi-Cal rather than coercing beneficiaries into mandatory managed care. Federal law requires that Medi-Cal managed care plans be paid actuarially sound rates based on compliance with requirements of state and federal law.

8. PPOs and HMOs: Timely Access Standards Must Apply to Both

From its inception, the Knox-Keene Act has regulated both HMOs and PPOs. S. 1367.03 (c) states that "In developing these standards, the department shall consider the nature of the plan network." This language simply requires the department to consider the nature of plan networks: it does not require different standards for HMOs and PPOs. Health Access would strongly oppose different standards for HMOs and PPOs.

9. Plan compliance with timely access standards: interaction with geographic access and language access: Compliance monitoring policies and procedures

In (d) (3), the proposed regulations provide for compliance monitoring policies and procedures, "designed to accurately measure the accessibility and availability of contracted providers".

In order to assure that the accurate measurement also reflects the requirements for geographic access and language access, we suggest the following changes in the proposed regulation:

(3) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to standards set forth in (c) *and consistent with S.1300.67.2.1 and S. 1300.67.04.*

(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at subsection (c) *and sufficient to ascertain compliance with standards set forth in S.1300.67.2.1 and S. 1300.67.04.*

10. Reliance on survey methodology: Public availability of survey instrument and methodology

During the informal stakeholders' discussions, plans, providers, and associations argued in favor of surveys to measure timely access to care. The CAHPS survey and other instruments created by NCQA are not publicly available documents; it is instead the creation of a private industry entity, available only at considerable cost, and not subject to either the open meetings law or the public records act and would not meet any standard or serve as a substitute measure for timely access.

For this reason, we suggest the following change to (h) (2) (F):

(F) The results of the most recent annual enrollee and provider surveys, the survey instruments and methodology for these surveys, and a comparison with results of the prior year's survey, including a discussion of the relative change in satisfaction and any changes resulting from a change in the questions asked or methodology used.

11. Plan compliance with timely access standards: interaction with geographic access and language access: Network adequacy

The proposed language in §1300.67.2.2 (h) requires the plan to report to the Department on an annual basis regarding their compliance for the preceding year. The regulation requires the plan to "separately report for each of the plan's contracted provider groups located in each *county* of the plan's service area." (Emphasis added)

While we concur with the observation by the department in the statement of reasons that county boundaries are rarely subject to change, county-level data is not sufficient to determine network adequacy consistent with geographic access requirements of the Knox-Keene Act and its regulations. This is particularly true for counties such as Los Angeles, San Bernardino, and San Diego, each of which has a geographic area comparable in size to Rhode Island. A directory of contracted primary care providers in Los Angeles County provides little meaningful information for establishing network

adequacy. In prior comments, we have suggested the use of "Medical Service Study Area" as established by the Office of Statewide Health Planning and Development. While the provision requiring geographic distribution of the plan's provider network is helpful in addressing this concern, it is not sufficient to assure good data for determining network adequacy.

Health Access supports the requirement in (h) (2) (G) (iii) and (iv) that each plan should submit with their report a map or other diagrammatic method for depicting the geographic distribution of the plan's enrollees, overlaid on the geographic distribution of the plan's provider network. This depiction of the plan's members superimposed on the plan's provider network would graphically highlight any misalignment in parts of the geographic service area where the plan should be concentrating their recruitment, retention, and alternative service model efforts. This will be helpful though not sufficient in determining network adequacy.

12. The Department should evaluate a plan's compliance with timely access including what might be construed as efforts to evade the intent of the law.

Health Access takes note that the proposed regulations address efforts by the plans to appear to offer service within a reasonable time frame, but which offer merely token adherence to the law. The proposed regulations address our concerns on these points in the sections noted:

- Referring enrollees to providers who are not appropriate for an enrollee's condition, (h) (3) (A)
- Referring enrollees to providers who are no longer accepting new patients, NOT
- Referring enrollees who do not have available appointment slots within reasonable time constraints, (c) (5) "contracted provider network has adequate capacity and *availability*".
- Referring enrollees to providers whose business location is beyond a reasonable travel distance for the consumer (except with the enrollee's explicit consent): (c) (7)
- Referring enrollees to providers who do not have sufficient support staff to schedule, confirm, reschedule, promptly return phone calls, report back to the referring physician, or perform other administrative functions to make that referral a reasonable option: (c) (8)

13. Timely access to care should be reflected on OPA Report Card.

AB2179 specifies that "the Department shall work with the patient advocate to assure that the quality of care report card incorporates information . . . regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care." Health Access appreciates that the statement of reasons acknowledges that (h) (2) is designed to provide information necessary for the Department to report to the Legislature and to share with the Office of Patient Advocate for disclosure to the public through the annual OPA Report Card.

Conclusion

Health Access commends the Department of Managed Health Care for proposing regulations that in large part implement AB2179 as intended and offers specific comments to amend those regulations to provide greater clarity and further consistency with statutory intent.

We intend to work closely with the Department on the implementation, monitoring, and enforcement of this law to provide consumers the protections that they seek.

If you need further information, please contact Elizabeth Abbott at Health Access at (916) 497-0923 or Beth Capell, Capell & Associates, at (916) 497-0760.

Sincerely,

Anthony Wright
Executive Director

CC: The Honorable David Jones, Chair, Assembly Health Committee
The Honorable Elaine Alquist, Chair, Senate Health Committee
Richard Figueroa, Office of the Governor
Cindy Ehnes, Director, Department of Managed Health Care
Ed Heidig, Principal Deputy, DMHC
Suzanne Chammout, Chief, Regulation Development Division, DMHC
Braulio Montesino, Assistant Deputy Director, DMHC
Richard Martin, Deputy Director, Financial Solvency Standards Board, DMHC

Attachments:

A. Access Standards for Top 7 Knox-Keene Plans by Enrollment: prepared by DMHC staff for DMHC Advisory Committee, 2002
B. Overuse of Emergency Departments Among Insured Californians, California Health Care Foundation, October 2006
C. Are the Uninsured Responsible for the Increase in Emergency Department Visits in the United States? Weber et al. Annals of Emergency Medicine. January 2008

June 24, 2009

Lucinda Ehnes, Director
Department of Managed Health Care
Office of Legal Services
Attn: Regulations Coordinator
980 9th St., Ste. 500
Sacramento, CA. 95814

Re: Timely Access to Non-Emergency Health Care Services
Second Comment Period
Control No. 2008-1579

Dear Ms. Ehnes,

Health Access, a coalition of more than a hundred consumer, community, communities of color and other organizations committed to quality, affordable health care for all Californians, offers comments on proposed regulations on Timely Access to Non-Emergency Health Care Services, Control No. 2008-1579.

Health Access California was the original sponsor of AB2179, c. 797 of 2002, which is the statutory authority for these regulations and we have been involved in the development of these regulations since the enactment of that measure.

We recognize that consistent with the Administrative Procedures Act, only comments on amended provisions are subject to consideration by the Department at this time.

Telephone Triage

The amendments to the proposed regulations substantially revise the provisions with respect to triage and screening services. The earlier version provided that triage and screening would be available from a qualified health professional acting with their scope of practice within ten minutes. The revised version allows 30 minutes to elapse prior to triage and screening being provided.

For genuine emergencies of many sorts (stroke, serious injury, heart attack), action within an hour of the event is critical to preventing or minimizing permanent harm. It is for that reason that emergency medical services professionals often refer to the "golden hour" and that so much of

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emergency medical care is designed to assure that patients are seen within an hour of the 911 call.

The requirement for timely triage and screening has been a key objective of Health Access. California's emergency rooms are over-crowded: contrary to popular mythology, most of the increase in crowding has resulted from increased use by persons with coverage. Timely triage ought to reduce inappropriate emergency utilization by providing consumers guidance as to whether they need to be seen promptly or can wait to receive urgent care within 48 hours.

Consumers are not clinicians. The current warning provided by some health providers that "if you think you have a life-threatening emergency, you should proceed to the nearest emergency room" is no help for a consumer who does not know and cannot be expected to know whether they have a life-threatening emergency. For example, is a baby with a sudden high fever an emergency or can the parent wait until the morning? What about a five year old child that has been throwing up for 45 minutes? What about a loved one in their 50s who has sudden severe stomach pain of a kind that the individual has never experienced?

Talking to a receptionist or an answering service is no substitute for a clinician's judgment. Existing California law rightly protects consumers by limiting triage and screening to qualified health professionals operating within scope of practice, primarily physicians and registered nurses. Clerical personnel by definition and by law lack the clinical education and training necessary to triage and screen. The relevant phone call is not the call to the doctor's office but the call from the doctor or the nurse to the consumer who is trying to decide whether or not to go to the emergency room.

It has been argued that timely access to triage is unduly burdensome to providers. Solo practitioners and practitioners in rural areas routinely provide coverage for other practitioners: being on call is a recognized part of the health delivery system and in many or most instances providers are paid for being on call. The intent of these regulations is to improve the timeliness of care in order to provide clinically appropriate care. While guidelines of professional organizations may be considered, the statute directs that the department consider the clinical appropriateness of care and the urgency of care in determining what the standard for the timeliness of access to care, including waiting time to speak to an appropriately qualified health professional.

California protects any consumer with coverage who reasonably believes they have an emergency: the law says that the insurer or health plan must pay for the emergency care.

The timely access regulations now provide the other key protection consumers need: the opportunity to find out in a timely manner whether they really need to go to the emergency room or whether they can avoid the miserable but sometimes necessary experience of going to an emergency room.

Given these facts, we are disappointed that the revised regulations propose to allow as much as 30 minutes before a consumer speaks to a health professional. A period of ten minutes or even fifteen minutes seems to us far more reasonable from a consumer perspective. From the perspective of the health care system, a ten or fifteen minute interval would be far more likely to reduce inappropriate emergency room utilization. An extra fifteen minutes may not seem very long most of the time but if you are afraid for yourself or someone you love, it can seem like a lifetime.

We recognize that the standards for dental, vision, chiropractic and acupuncture plans are different: as the statute recognizes, standards may be different if clinically appropriate. We appreciate that the regulations require that plans assure that consumers may obtain urgent and emergency care as needed.

Standards for Timely Access to Care: Provisions of Services Out of Network

We offer comments on (c) (7) (B) regarding the requirements on a plan if the plan has a shortage of providers necessary to ensure timely access to care. We support the revised language requiring that if a consumer is referred out of network because of a shortage of in-network providers with the appropriate expertise, then the consumer would pay the in-network cost sharing. This is appropriate because the consumer should not be penalized for the failure of the plan to construct an adequate network and because it creates a further incentive for an adequate network.

We are troubled by the following sentence:

> This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

Consumers are not clinicians. If care is needed more urgently than it can be provided by a specific contracted provider, the consumer should be

seen more quickly. We recognize that it is the view of the department that the governing provision is that

> (c) (1) Plans shall provide for or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

However, as consumers we know that plans can delay care through a variety of mechanisms. In interpreting these regulations, it is essential that clinical appropriateness trump the preferences of a consumer for a specific provider.

Standards for Timely Access to Care: Administrative Capacity of Providers

The prior version of the regulations required that plans ensure that providers have administrative capacity to perform the necessary tasks in a timely manner. Testimony at the hearings indicated that timeliness of access is often lacking in referrals to specialists and in follow-up care. While providers may object to any requirements, preferring to provide care at a pace convenient to themselves, the capacity to provide timely care is basic to good care.

Compliance Monitoring: Network Adequacy

The provisions of (d) (2) (F) monitor adequacy of network at a county-level: this does not provide sufficient data to allow the department to monitor compliance with the existing regulations on geographic access, the standard that generally care should be available within 15 miles or 30 minutes. For example, San Bernardino County is a larger geographic area than the state of Rhode Island. Los Angeles County alone has a population larger than Massachusetts or New Jersey or indeed than all but seven states, including California. It takes three hours to drive from Blythe to Corona but both are within Riverside County. Monitoring of network adequacy requires better data: if the department intends to collect better data, the regulation should reflect that.

Disclosure to Consumers

The protections of these timely access regulations will be meaningless unless consumers know that these protections exist. It is essential that plans be required to tell consumers of these protections. Absent such a

requirement, plans have no reason to inform consumers of these protections which the plans have bitterly resisted.

For that reason, we are pleased to see the requirement that plans inform consumers of the availability of triage and screening in the evidence of coverage and that plans disclose to consumers annually the plan's standards for timely access. If consumers have the information about the standards for timely access to care, consumers can know what they may reasonably expect in terms of timeliness.

We would have preferred that both the triage and the timeliness standards be included in both the evidence of coverage as well as annual communications with enrollees. Timely access is a basic benefit that was recognized in the original language of the Knox-Keene Act: AB2179 simply directed that the Department create a set of enforceable standards through the regulation package on which we now comment. We see no reason why these standards should not be incorporated in both the evidence of coverage and annual communications with enrollees.

Conclusion

Finally, we take note that the standards for timeliness of access have not otherwise been amended in this revision of the regulations. We continue to support concrete and knowable standards for timeliness of access that are based on time-elapsed standards.

We look forward to working with the Department during implementation of these regulations.

Sincerely

Anthony Wright
Executive Director

CC: Senator Elaine Alquist, Chair, Senate Health Committee
Assemblymember Dave Jones, Chair, Assembly Health Committee

August 7, 2009

Lucinda Ehnes, Director
Department of Managed Health Care
Office of Legal Services
Attn: Regulations Coordinator
980 9th St., Ste. 500
Sacramento, Ca. 95814

Re: Third Comment Period: Control No. 2008-1579.

Dear Director Ehnes,

Health Access California offers comments on third comment period for Timely Access to Non-Emergency Health Care Services. As we have noted in prior comments, we were the sponsors of the authorizing legislation and have worked to accomplish timely access to care for more than a decade.

Health Access takes note of a potential conflict between the revised language with respect to "advanced access" and the requirement to provide timely access to urgent care.

Specifically the revised language for "advanced access" defines it as offering an appointment to an enrollee on the "same or next business day from the time an appointment is requested". The next business day may fall several days after the request if the request is made on a Friday or on the day before a holiday. For example, if someone made a request on the Wednesday before Thanksgiving, the next business day would likely be five days later on Monday.

The standard for urgent care is to provide an appointment within 48 hours for services that do not require prior authorization or 96 hours for services that require prior authorization. The availability of timely urgent care is essential in order to minimize avoidable emergency room utilization. If consumers cannot get timely urgent care, they will end up in an emergency room in order to obtain timely care.

Health Access urges that the Department clarify that the standard for urgent care applies in the context of "advanced access" as well. If someone seeks care on the Wednesday before Thanksgiving and needs it urgently, they should not be required to wait until Monday or be forced to go to an emergency room unnecessarily: instead urgent care should be made available to that enrollee. As the Department has repeatedly asserted, clinical appropriateness governs. If an enrollee needs care urgently, then the enrollee should not be forced to wait longer than 48 hours if no prior authorization is required.

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We urge clarification on this point so that consumers, providers and plans are assured of timely access to urgent care.

Health Access takes note that most of the other proposed changes are technical.

Sincerely,

Anthony Wright
Executive Director

CC: Suzanne Chammout, Chief, Regulations Development Division
Senator Elaine Alquist, Chair, Senate Health Committee
Assemblymember Dave Jones, Chair, Assembly Health Committee

C A L I F O R N I A

October 12, 2009

Lucinda Ehnes, Director
Department of Managed Health Care
Office of Legal Services
Attn: Regulations Coordinator
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Fourth Comment Period on Timely Access to Non-Emergency Services
Control No: 2008-1579

Dear Director Ehnes:

Health Access California offers comments on the fourth comment period for Timely Access to Non-Emergency Health Care Services. As we have noted in our prior comments, we were the sponsors of the authorizing legislation and have worked to accomplish timely access to care for more than a decade.

Use of the Strongest Language to Document Exceptions to Timely Access.

In the standards for timely access to care outlined in §1300.67.2.2 (c)(5)(G), the Department has substituted the verb "noted" for "documented" as the requirement for extension of an appointment beyond the stipulated time frames. In reasonably infrequent circumstances the health professional can make a determination that a longer waiting time will not have a detrimental impact on the health of the enrollee.

The reason for making a specific written record of the exception to timely access is that a time extension should not be done casually or as a matter of course. We argue that the enrollee may make such a request for the delay in the appointment time based on personal convenience or preference for a specific provider without a clear understanding of the clinical consequences. The level of detail required in the documentation should have sufficient specificity to assure that the delay granted is based on purely clinical considerations because any delay in care could have serious consequences for the patient.

In what should be the limited use of this exception, we prefer the stronger word document. The difference between the definitions of these two words is the degree of formality and detail associated with the requirement to document the decision. We do not believe the substitution of the verb

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noted in any way enhances the requirement that particular care should be exercised in granting any additional delay in seeing a health care professional. We believe that the potentially seriousness consequences of the delay requires the most explicit and strongest documentation standard. As any nurse can attest based on training and experience: "If it is not documented, it did not happen."

The Role of Unlicensed Staff in Screening and Triage.

We support the language of the statute that restricts the granting of an exception to the timely access standards to licensed medical professionals practicing in the scope of their medical specialty. Consequently, we are concerned about your insertion of new language in §1300.67.2.2 (c)(8)(B)(iii) that makes a distinction between the latitude given to licensed as opposed to unlicensed staff.

The new language implies that unlicensed staff may elicit the answers to "screening" questions regarding appointments for or referrals to medical personnel, but may not use those answers to "assess, evaluate, advise, or make any decisions" regarding the enrollee's request. We believe that in the course of doing actual screening and triage, these functions tend to overlap. In essence, even with this specific language in the regulation which prohibits the unlicensed staff from performing evaluations or giving advice, these functions tend to blur in practice.

Consequently, we believe that the delegation of even preliminary medical screening questions to non-licensed customer service representatives can result in delays in enrollees seeing qualified medical personnel for consultation and treatment. We prefer that the screening function be performed by licensed medical professionals (as some plans and groups currently do) to avoid any possibility of adverse health consequences to patients as a result of those delays or improper referrals. As a result, the language in the regulation should not countenance even a limited role for non-medical personnel in the medical screening process.

Alternate Method of Demonstrating Network Adequacy

In §1300.67.2.2 (g)(1) the regulation describes the mechanism for establishing an "alternative method of demonstrating network adequacy." We are concerned about the language which offers a plan the option of

proposing a measurement of network adequacy by other than physician-to-enrollee ratios within the plan's geographic areas.

We believe the use of general, non-quantitative, or soft measures of network adequacy has not historically resulted in a plan's ability to provide timely access to care. Plans have long asserted that they routinely offer **timely access to care,** perhaps because it has been a requirement since the original Knox-Keene legislation.

However, this has not consistently been true. Specifically, plans have failed to set their own clear, unambiguous, time-elapsed standards. They have neglected to do any self-assessment of whether their amorphous standards had been met by contracted or non-contracted providers. In addition, the Department has failed to rigorously monitor the plans' compliance in truly delivering timely access to care. These failures, in fact, provided the impetus to the passage of the current legislation. Consequently, we strenuously oppose watering down the oversight and compliance language in the regulation to include exceptions and alternate mechanisms for proving compliance since it has been so singularly ineffective for more than three decades.

In addition, we have consistently objected to permitting the plans' use of a material modification for alternative standards because there is no transparency or public involvement in that largely internal process. Any alternative measure of timely access proposed by health plans should be open to scrutiny by consumers, advocates, and the public, as should the departmental review process of their request.

Documentation Requirements of the Plan's Provider Network and Enrollment

We support the additional specificity to the documentation requirements outlined (g)(2)(G). However, we object to the elimination of the map requirement described in (iii). This is a particularly useful proof of network adequacy and timely access because of the size of several counties in California. No plan could argue that they were providing timely access to care if they contracted with large numbers of providers in the San Fernando Valley, but virtually none in south central Los Angeles. Although both of these communities are part of Los Angeles County, there are huge differences between them because of distance, communities, neighborhoods, proximity, transportation corridors, language and ethnicity. Similar assertions would fall flat in San Bernardino County, the largest

geographic county in the U. S. The map of the plan's provider network makes these insufficiencies easily visible, and hence more easily detected and overcome. The language in (iii) should be restored.

If you have questions or need more information, do not hesitate to contact Elizabeth Abbott on my staff at (916) 497-0923, ext. 201 or Beth Capell, Capell & Associates, at (916) 497-0760. We look forward to working with the Department on the implementation of this final regulation.

Sincerely,

Anthony Wright

Anthony Wright
Executive Director
Health Access

cc: Dave Jones, Chair, Assembly Health
Elaine Alquist, Chair, Senate Health
Lucinda Ehnes, Director, Department of Managed Health Care
Ed Heidig, Deputy Director, Department of Managed Health Care

2002-001, 2005-0203	Time Recorded for:	Elizabeth Capell, Health Care Policy Expert			
Date	Time	Activity	Time Elapsed Number of Hours	Hourly Rate	Billed Amount
8/2/2004	4:30p.m.-5:00 p.m.	Reviewing draft of DMHC public hearing on Timely Access to Care	0.5	$350	$175
8/15/2004	4:30 p.m.-5:30 p.m.	Preparation for DMHC public hearing on Timely Access to Health Care Services	1	$350	$350
8/16/2004	10:00 a.m.-12:00 p.m.	Attended DMHC public hearing on timely access to care	2	$350	$700
9/10/2004	11:30 a.m.-12:00 p.m.	Meeting with Western Center regarding upcoming meeting with DMHC	0.5	$350	$175
9/13/2004	6:00 a.m. -7:00 a.m.	Revising comments prior to managers and staff meeting on revision to timely access to care regulation	1	$350	$350
9/13/2004	1:00 p.m.-4:00 p.m.	Meeting with DMHC managers and staff on revision to timely access to care regulation	3	$350	$1,050
10/15/2004	10:30 a.m.-11:00 a.m.	Prepared and edited comments to DMHC on Timely Access to Care	0.5	$350	$175
10/17/2004	3:00 p.m.-5:00 p.m.	Prepared and edited comments to DMHC on Timely Access to Care	2	$350	$700
10/18/2004	4:30 p.m.-5:00 p.m.	Prepared and edited comments to DMHC	0.5	$350	$175
12/7/2004	2:00 p.m.-5:00 p.m.	Prepared and edited comments to DMHC on Timely Access to Care	3	$350	$1,050
12/9/2004	11:00 a.m.-11:30 a.m.	Prepared and edited comments to DMHC 12/7/04	0.5	$350	$175
6/17/2005	5:00 a.m.-6:00 a.m.	Preparation for meeting	1	$360	$360
6/17/2005	2:00 p.m.-4:00 p.m.	Meeting with DMHC managers and staff on revision to timely access to care regulation	2	$360	$720
1/2/2006	8:00a.m.-8:30 a.m.	Prepared comments and edited draft from 12/13/05	0.5	$370	$185
1/8/2006	9:00a.m.-9:30 a.m.	Prepared comments and edited draft from 12/13/05	0.5	$370	$185
1/29/2006	12:30 p.m.-1:00 p.m.	Prepared comments and edited draft from 12/13/05	0.5	$370	$185
1/31/2006	3:30 p.m.-4:30 p.m.	Prepared comments and edited draft from 12/13/05	1	$370	$370

10/6/2006	1:30 p.m.-2:30 p.m.	Reviewed document distributed by DMHC on proposed timely access to care regulation, previous oral and written testimony presented to Health Access on the issue, comparative standards of the top seven health plans, and the underlying statute.	1	$370	$370
10/16/2006	3:30 p.m.-4:00 p.m.	Reviewed document distributed by DMHC on proposed timely access to care regulation, previous oral and written testimony presented to Health Access on the issue, comparative standards of the top seven health plans, and the underlying statute.	0.5	$370	$185
10/17/2006	3:00 p.m.-5:00 p.m.	Advocate pre-meeting with Western Center	2	$370	$740
10/19/2006	9:30 a.m.-12:30 p.m.	Preparation with Western Center for Meeting with DMCH	3	$370	$1,110
10/23/2006	2:00 p.m.-5:00 p.m.	Stakeholder meeting	3	$370	$1,110
10/24/2006	1:30 p.m.-4:30 p.m.	Meeting with DMHC- Steven Hansen and Warren Barnes	3	$370	$1,110
10/27/2006	9:30 a.m.-12:00 p.m.	Stakeholder meeting	2.5	$370	$925
11/3/2006	9:30 a.m.-12:00 p.m.	Stakeholder meeting	2.5	$370	$925
11/14/2006	11:00 a.m.-2:00 p.m.	Stakeholder meeting	3	$370	$1,110
11/15/2006	10:00 a.m.-1:00 p.m.	Stakeholder meeting	3	$370	$1,110
3/3/2007	6:30 a.m.-8:00 a.m.	Prepared comments and edited draft for hearing 3/5/07	1.5	$380	$570
3/4/2007	8:00 a.m.-8:30 a.m.	Prepared comments and edited draft for hearing 3/5/07	0.5	$380	$190
3/5/2007	10:00 a.m.-2:00 p.m.	Attended DMHC public hearing on timely access to care	2	$380	$760
8/13/2007	10:00 a.m.- 2:00 p.m.	Attended DMHC public hearing on timely access to care	2	$380	$760
9/17/2007	2:00 p.m.-3:00 p.m.	Meeting with Western Center, Health Rights Hotline, and CMS	1	$380	$380
9/18/2007	10:00 a.m.- 12:00 p.m.	Attended DMHC public hearing on timely access to care	2	$380	$760
9/20/2007	7:45 p.m.-8:45 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services, control #2005-0203	1	$380	$380
9/21/2007	2:00 p.m.-4:00 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services, control #2005-0203	2	$380	$760
1/18/2008	2:00 p.m.-3:30 p.m.	Meeting with Director Ehnes regarding Regulations	1.5	$390	$585
1/19/2008	1:30p.m.-3:00p.m.	Conference call with DMHC leadership on third revision of Timely Access to Care regulation	1.5	$390	$585

2/5/2008	11:00 a.m.-11:30 a.m.	pre-meeting conference call with Elizabeth Landsberg, Western Center on Law and Poverty	0.5	$390	$195
2/5/2008	2:00 p.m.-4:00 p.m.	Meeting with DMHC managers and staff on revision to timely access to care regulation	2	$390	$780
3/5/2008	3:00 p.m.-3:15 p.m.	Voices of Consumers Meeting with DMHC Managers and Staff	0.25	$390	$98
3/13/2008	11:00 a.m.-12:00 p.m.	Voices of Consumers Meeting with DMHC Managers and Staff	1	$390	$390
6/18/2008	1:00 p.m.-2:30 p.m.	Reviewing draft and drafting comments regarding Timely Access to Care to be sent to the DMHC	1.5	$390	$585
6/27/2008	5:30 a.m.-5:45 a.m., 8:18 a.m.-8:45 a.m., 12:00 p.m.- 3:30 p.m.	Reviewing draft and drafting comments regarding Timely Access to Care to be sent to the DMHC	2.25	$390	$878
6/30/2008	12:30p.m- 3:30p.m.	Attended session introducing the process to be used by the DMHC to draft the Timely Access to Care regulation	3	$390	$1,170
7/1/2008	8:00 a.m.-8:30 a.m.	Drafted early comments to Ed Heidig, Tim LeBas, Braulio Montesino and Suzanne Chammout regarding Timely Access regulations	0.5	$390	$195
7/7/2008	11:00 a.m.-11:30 a.m.	Confirm primary identity of spokespersons for Health Access	0.5	$390	$195
7/20/2008	11:00 a.m.-1:00p.m.	Drafted early comments to Elizabeth Landsberg regarding Timely Access regulations	2	$390	$780
7/24/2008	3:30 p.m- 4:30 p.m	comments and editing of positions of Health Access on the DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	1	$390	$390
7/25/2008	3:00 p.m.-4:00 p.m	Review all stakeholder comments of the DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	1	$390	$390
7/28/2008	9:00 a.m.-5:00 p.m.	DMHC Workshop meeting	8	$390	$3,120
7/30/2008	9:00 a.m.-5:00 p.m.	DMHC Workshop meeting	8	$390	$3,120
8/4/2008	9:00 a.m.-5:00 p.m.	DMHC Workshop meeting	8	$390	$3,120
8/7/2008	8:00 a.m.-3:00 p.m.	OSHPD Workshop meeting	7	$390	$2,730
8/21/2008	2:00 p.m.-3:00 p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	1	$390	$390

8/22/2008	9:00 a.m.-10:00 a.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	1	$390	$390
9/3/2008	9:00 a.m.-12:30 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 1	3.5	$390	$1,365
9/4/2008	9:00 a.m.-12:00 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 2	3	$390	$1,170
9/10/2008	9:00 a.m.-2:30 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 3 and 4	5.5	$390	$2,145
9/11/2008	9:00 a.m-1:45 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 5, 6, and 7	4.75	$390	$1,853
10/30/2008	1:30-3:00 p.m.	Attended informal consultation meeting with Rick Martin and Tim LeBas at DMHC on Timely Access to Care regulation	1.5	$390	$585
11/20/2008	5:30 a.m.-6:00 a.m.	Drafted early comments to Marty Martinez and Elizabeth Landsberg regarding Timely Access regulations	0.5	$390	$195
11/24/2008	11:00 a.m.-1:00p.m., 1:35 p.m.-5:00p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	5.25	$390	$2,048
11/25/2008	10:40 a.m.-12:05 p.m., 1:00 p.m.-4:20 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	4.75	$390	$1,853
1/8/2009	5:00 a.m.-6:00 a.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390
2/12/2009	4:15p.m.-4:45 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	0.5	$390	$195
2/18/2009	10:00 a.m.-11:00 a.m.	Research and write comments on DMHC regulation on Timely Access to health care services	3	$390	$1,170
2/19/2009	12:30 p.m.-1:30p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390
2/19/2009	4:30 p.m.-5:30 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390
2/21/2009	7:30 a.m.-9:00 a.m.	Research and write comments on DMHC regulation on Timely Access to health care services	2	$390	$780
2/22/2009	7:00 a.m.-8:00 a.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390

2/22/2009	12:00 p.m.-5:00 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	5	$390	$1,950
2/23/2009	6:00 a.m.-7:00 a.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390
2/23/2009	9:00 a.m.-11:00 a.m.	Research and write comments on DMHC regulation on Timely Access to health care services	2	$390	$780
2/23/2009	2:00 p.m.-4:00 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	2	$390	$780
6/1/2009	4:00 p.m.-4:45 p.m.	Conference call with DMHC leadership on Timely Access to Care regulation	0.75	$390	$293
6/4/2009	9:00 a.m.-10:00 a.m.	Conference call with DMHC leadership on Timely Access to Care regulation	1	$390	$390
6/19/2009	11:30 a.m.-12:30 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390
6/24/2009	1:30 p.m.-2:30 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	1	$390	$390
6/25/2009	1:00p.m.-1:30 p.m.	Research and write comments on DMHC regulation on Timely Access to health care services	0.5	$390	$195
SUBTOTAL		**Elizabeth Capell**	**159.5**		**$60,895**
2002-0018, 2005-0203	**Time Recorded for:**	**Anthony Wright, Health Care Policy Expert**			
8/3/2004	2:00p.m.-3:00pm	Review research on timely access	1	$230	$230
8/15/2004	6:00 p.m.- 6:30pm	Prep for DMHC public hearing	0.5	$230	$115
8/16/2004	10:00 a.m.-12:00 p.m.	Attended DMHC public hearing on timely access to care	2	$230	$460
9/10/2004	5:00 p.m.- 5:15 p.m.	Review research on timely access	0.25	$230	$58
9/13/2004	9:00 a.m.-11:00 a.m.	Prepared and edited comments to DMHC	2	$230	$460
10/16/2004	1:30 p.m.-2:30 pm	Review research and comments on timely access	1	$230	$230
12/9/2004	11:00 a.m.-11:30 a.m.	Prepared and edited comments to DMHC 12/7/04	0.5	$230	$115
6/17/2005	5:30 p.m. -6:00 p.m.	Debrief from DMHC meeting	0.5	$240	$120
1/29/2006	1:00 p.m. -1:30 p.m.	Review draft comments and continue editing comments on timely access	0.5	$250	$125
10/7/2006	11:00 a.m.-12:00 p.m.	Review DMHC documents and provide initial comments	1	$250	$250
11/16/2006	4:00 p.m. -5:00 p.m.	Debrief on stakeholder meetings, and plan next steps	1	$250	$250

1/18/2007	2:45 p.m.-3:15 p.m.	Review regulations and comments in preparation for call with Cindy Ehnes	0.5	$260	$130
1/24/2007	1:00 p.m.-3:00p.m.	Review Emergency Room literature, write beginning comments, and draft public commentary on proposed regulations	2	$260	$520
1/24/2007	2:06 p.m.-3:06 p.m.	Draft public commentary on proposed regulations regarding delayed care	1	$260	$260
2/5/2007	2:30 p.m.-3:00 p.m.	DMHC Meeting with Consumer Groups (with a selection on timely access)	0.5	$260	$130
3/4/2007	3:00 p.m.-4:00p.m.	Review and help prepare hearing comments	1	$260	$260
3/5/2007	4:30 p.m.-5:00 p.m.	Debrief from DMHC meeting	0.5	$260	$130
8/3/2007	2:30 p.m.-2:45 p.m.	Brief/get input from consumer coalition on timely access	0.25	$260	$65
9/17/2007	11 a.m.-12:00 p.m.	Review/prepare for DMHC hearing	1	$260	$260
9/18/2007	11:00 a.m.-1:30 p.m.	Attended DMHC timely access hearing	2.5	$260	$650
9/21/2007	11:10 p.m.-12:10 a.m.	Draft public commentary on proposed regulations regarding timely access to care standards being debated	1	$260	$260
9/21/2007	4:00 p.m.-5:15 p.m.	Review, edit and finalize DMHC comments	1.25	$260	$325
12/11/2007	1:15p.m.-1:30 p.m.	Brief/get input from consumer coalition on timely access	0.25	$260	$65
12/20/2007	1:00 p.m.-2 p.m.	Review new proposed regulations and provide initial guidance	1	$260	$260
12/26/2007	3:00 p.m.-4:00 p.m.	Edit and finalize DMHC comments	1	$260	$260
1/19/2008	1:30 p.m.-3:00 p.m.	Conference call with Cindy Ehnes/ DMHC leadership on third revision of Timely Access to Care regulation	1.5	$270	$405
2/1/2008	12:00 p.m.-1:00 p.m.	Spoke with consumers about timely access issues, including Bobby Perry, regarding testimony	1	$270	$270
2/5/2008	11:00 a.m.-11:30 a.m.	Pre-meeting conference call with Elizabeth Landsberg, Western Center on Law and Poverty	0.5	$270	$135
2/5/2008	2:00 p.m.-4:00 p.m.	Meeting with DMHC managers and staff on revision to timely access to care regulation	2	$270	$540
2/5/2008	4:30 p.m.-5:00 p.m.	Meeting with Daniel Zingale of Governor Schwarzenegger's office regarding Timely Access	0.5	$270	$135
2/5/2008	9:15 p.m.-10:15 p.m.	Drafted public commentary on proposed regulations regarding HMO self-regulation	1	$270	$270

2/8/2008	12:55 a.m.-2:55 a.m.	Drafted public commentary on proposed regulations regarding setting strong standards on timely access to care for the state	2	$270	$540
2/27/2008	6:44 p.m.-8:44 p.m.	Reviewed history of regulations, drafted public commentary and timeline on proposed regulations, responding to the Office of Administrative Law return of regulations	2	$270	$540
2/29/2008	2:00 p.m.-2:30 p.m.	Brief/get input from consumer coalition on timely access	0.5	$270	$135
3/5/2008	3:00 p.m.-3:15 p.m.	Voices of Consumers Meeting with DMHC Managers and Staff	0.25	$270	$68
3/6/2008	12:00 p.m.-12:30 p.m.	Meeting with Cindy Ehnes	0.5	$270	$135
3/10/2008	5:40 p.m.-6:40 p.m.	Researched and drafted public commentary on proposed regulations regarding timely access to care	1	$270	$270
3/18/2008	3:00 p.m.-4:00 p.m.	Business, Housing and Transportation Department meeting with Catherine Lowell	1	$270	$270
3/21/2008	5:15 p.m.-5:30 p.m.	Meeting with Dan Dunmoyer of Governor Schwarzenegger's Office	0.25	$270	$68
3/27/2008	9:10 p.m.-10:10 p.m.	Reviewed research and positions on timely access	1	$270	$270
4/15/2008	9:45 p.m.-10:45 p.m.	Reviewed new research on emergency room use and timely access, and drafted public commentary	1	$270	$270
7/24/2008	4:10 p.m.-5:40 p.m.	Reviewed and edited Health Access response to seven issues regarding timely access to care	1.5	$270	$405
8/1/2008	2:15 p.m.-2:30 p.m.	Brief/get input from consumer coalition on timely access	0.25	$270	$68
8/7/2008	9:50 p.m.-11:20 p.m.	Reviewed new research on emergency room use and overcrowding regarding timely access to care, and drafted language and public commentary on proposed regulations	1.5	$270	$405
8/19/2008	1:45 p.m.-2:45 p.m.	Review, edited, and prepared comments to DMHC seven issues on Timely Access to Care	1	$270	$270
8/22/2008	4:00 p.m.-5:30 p.m.	Reviewed and edited Health Access response to seven issues regarding timely access to care	1.5	$270	$405
9/11/2008	3:30 p.m.-4:30 p.m.	Debrief DMHC stakeholders workshops	1	$270	$270
11/24/2008	12:00 p.m.-1:00 p.m., 2:30 p.m.-5:00 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	3.5	$270	$945

11/25/2008	11:30 a.m.-12:00 p.m., 2:20 p.m.-4:20 p.m.	Researched and prepared written reponse to DMHC on revised timely access to care regulation	3	$270	$810
12/11/2008	1:45 p.m.-2:15 p.m.	Brief/get input from consumer coalition on timely access	0.5	$270	$135
1/26/2008	10:10 a.m.-11:55 a.m.	Drafted and edited summary and analysis of new version of timely access regulations	1.75	$270	$473
2/20/2009	4:42 p.m.-6:12 p.m.	Review and draft public commentary on proposed regulations regarding the recent hearing	1.5	$270	$405
2/23/2009	2:30 p.m.-4:00 p.m.	Review and edit comments on DMHC regulation on Timely Access	1.5	$270	$405
2/24/2009	11:00 p.m.-11:30 p.m.	Review and research timely access to care as it relates to emergency room use	1.5	$270	$405
6/24/2009	2:00 p.m.-3:00 p.m.	Review and edit comments on DMHC regulation on Timely Access	1	$270	$270
6/25/2009	1:30 p.m.-2:00 p.m.	Review and edit comments on DMHC regulation on Timely Access	0.5	$270	$135
1/20/2010	12:10 a.m.-1:10 a.m.	Reviewed and summarized final analysis of timely access regulation, and drafted public commentary	1	$270	$270
SUBTOTAL		**Anthony Wright**	**62.50**		**$16,383**
2002-0018, 2005-0203	**Time Recorded for:**	**Elizabeth Abbott, Health Care Policy Expert**			
10/16/2006	9:00 a.m.-11:00 a.m.	Reviewed document distributed by DMHC on proposed timely access to care regulation, previous oral and written testimony presented to Health Access on the issue, comparative standards of the top seven health plans, and the underlying statute.	2	$370	$740
10/17/2006	3:00 p.m.-5:00 p.m.	Jointly reviewed the document distributed by DMHC on their proposed timely access to care regulation, comparative standards of the top seven health plans, and the underlying statute. We developed key areas of concern with the proposed regulation and outlined questions and concerns to present to DMHC	2	$370	$740

10/24/2006	1:30 p.m.-4:30 p.m.	Discussion on draft document with staff from DMHC on the proposed timely access to care regulation. Key areas of concern were raised with the proposed regulation and outlined, questions regarding the proposed standards, monitoring protocols, enforcement mechanisms, and language of the proposed regulation	3	$370	$1,110
3/4/2007	3:00 p.m-5:00 p.m.	Preparation for DMHC public hearing on timely access to care and testimony in favor of the time-elapsed standards and other measurements of compliance recommended by the DMHC in their regulatory language	2	$380	$760
3/5/2007	9:00 a.m.-3:30p.m.	Attended and gave testimony at DMHC public hearing on timely access to care and prepared and submitted written comments to the Department	6.5	$380	$2,470
3/9/2007	8:45 a.m.-11:00 a.m.	Prepare regulatory update on pending DMHC timely access regulations	2.25	$380	$855
9/17/2007	9:00 a.m.-12:00 p.m.	Prepared oral testimony for presentation at the DMHC hearing on timely access to health care services	3	$380	$1,140
9/18/2007	8:00 a.m.-2:30 p.m.	Gave oral testimony, listened to all other testimony at DMHC public hearing on Timely Access to Health Care Services	6.5	$380	$2,470
9/19/2007	9:15a.m.-12:00 p.m., 12:50 p.m.-4:50 p.m.	Prepared and revised written testimony for submission to the DMHC	6.75	$380	$2,565
9/20/2007	8:45 a.m.-11:00 a.m.	Prepare regulatory update on pending DMHC timely access regulations	2.25	$380	$855
9/21/2007	2:30 p.m.-3:15 p.m.	Prepared and revised written testimony for submission to the DMHC	0.75	$380	$285
12/24/2007	1:10p.m.-5:15p.m.	Research and prepare written comments on revised regulation to DMHC	4	$380	$1,520
12/25/2007	9:30 a.m.-12:30 p.m., 1:45 p.m-3:45 p.m.	Research and prepare written comments on revised regulation to DMHC	5	$380	$1,900
12/26/2007	9:45 a.m.-2:45 p.m.	Research and prepare written comments on revised regulation to DMHC	5	$380	$1,900

1/19/2008	1:30 p.m.-3:00p.m.	Conference call with DMHC leadership on third revision of Timely Access to Care regulation	1.5	$390	$585
2/5/2008	11:00 a.m.-11:30 a.m.	Pre-meeting conference call with Elizabeth Landsberg, Western Center on Law and Poverty	0.5	$390	$195
2/5/2008	2:00 p.m.-4:00p.m.	Meeting with DMHC managers and staff on revision to timely access to care regulation	2	$390	$780
2/28/2008	9:30 a.m.-11:00 a.m.	Prepare regulatory update on pending DMHC timely access regulations	1.5	$390	$585
3/5/2008	3:00 p.m.-3:15p.m.	Voices of Consumers Meeting with DMHC Managers and Staff	0.25	$390	$98
3/13/2008	11:00 a.m.-12:00 p.m.	Voices of Consumers Meeting with DMHC Managers and Staff	1	$390	$390
3/18/2008	3:00 p.m.-4:00 p.m.	Business, Housing and Transportation Department meeting with Catherine Lowell	1	$390	$390
6/30/2008	1:00p.m.-3:30p.m.	Attended the session introducing the process to be used by the DMHC to draft the Timely Access to Care regulation	2.5	$390	$975
7/22/2008	10:45 a.m.-5:15 p.m.	Comments and editing of positions of Health Access on the DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	6.5	$390	$2,535
7/23/2008	10:00 a.m.-6:00 p.m.	Comments and editing of positions of Health Access on the DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	8	$390	$3,120
7/24/2008	11:45 a.m.-3:45 p.m.	Comments and editing of positions of Health Access on the DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	4	$390	$1,560
8/13/2008	10:45 a.m.-5:15 p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	6.5	$390	$2,535
8/18/2008	10:00 a.m.-2:00p.m., 3:30p.m.-6:00p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	6.5	$390	$2,535

8/19/2008	11:45 a.m.-3:45 p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	4	$390	$1,560
8/20/2008	12:45 p.m.-4:45 p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	4	$390	$1,560
8/21/2008	11:30 a.m.-5:30 p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	6	$390	$2,340
8/22/2008	10:30 a.m.-4:30 p.m.	Comments and editing the response of Health Access to the positions of the other stakeholders to DMHC seven issues pertaining to the drafting of the Timely Access to Care regulation	6	$390	$2,340
9/3/2008	9:00 a.m.-12:30p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 1	3.5	$390	$1,365
9/4/2008	9:00 a.m.-12:00 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 2	3	$390	$1,170
9/10/2008	9:00 a.m.-2:30 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 3 and 4	5.5	$390	$2,145
9/11/2008	9:00 a.m.-1:45 p.m.	Attended Stakeholders Workshops at DMHC on Timely Access Issue 5, 6, and 7	4.75	$390	$1,853
9/22/2008	3:10 p.m.-3:40 p.m.	Consultation with Don Berwick at the International Quality Institute in Cambridge, MA regarding academic research on Timely Access to Care regulation via email and telephone	0.5	$390	$195
10/30/2008	1:30 p.m.-2:30 p.m.	Attended informal consultation meeting with Rick Martin and Tim LeBas at DMHC on Timely Access to Care regulation	1	$390	$390
11/24/2008	11:00 a.m.-1:00 p.m., 1:35 p.m.-5:00 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	5.25	$390	$2,048
11/25/2008	10:40 a.m.-12:05 p.m.-1:00 p.m.-4:20 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	4.75	$390	$1,853
12/9/2008	3:05 p.m.-3:20p.m.	Prepare regulatory update on three pending DMHC regulations	0.25	$390	$98

12/16/2008	2:20 p.m.-4:00 p.m.	Prepare chart of revisions and notes to compare Health Access' comments to DMHC on timely access to the Department's final submissions to OAL	1.25	$390	$488
1/6/2009	9:00 a.m.-10:15 a.m.	Prepare regulatory update on final timely access regulations	1.25	$390	$488
2/9/2009	11:10 a.m.- 12:10 p.m., 1:20 p.m.-4:20 p.m.	Researched and edited written response to DMHC on revised timely access to care	4	$390	$1,560
2/10/2009	1:00 p.m.-3:30 p.m.	Researched and edited written response to DMHC on revised timely access to care	2.5	$390	$975
2/11/2009	11:00 a.m.-11:30 a.m.	Researched and edited written response to DMHC on revised timely access to care	0.5	$390	$195
2/12/2009	8:30 a.m.-9:00 a.m.	Researched and edited written response to DMHC on revised timely access to care	0.5	$390	$195
2/13/2009	1:45 p.m.-3:00 p.m.	Researched and edited written response to DMHC on revised timely access to care	2.25	$390	$878
6/11/2009	1:15 p.m.-2:15 p.m.	Researched and edited written response to DMHC on revised timely access to care	1	$390	$390
8/5/2009	9:05 a.m.-10:20 a.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	1.5	$390	$585
10/8/2009	2:20 p.m.-4:20 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	2	$390	$780
10/9/2009	1:10 p.m.-4:15 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	3	$390	$1,170
10/12/2009	11:00 a.m.-12:00 p.m.	Researched and prepared written response to DMHC on revised timely access to care regulation	1	$390	$390
10/23/2009	1:10 p.m.-1:40 p.m.	Prepare regulatory update on pending DMHC timely access regulations	0.5	$390	$195
11/19/2009	3:45 p.m.-4:30 p.m.	Prepare regulatory update of pending DMHC timely access regulations	0.75	$390	$293
12/21/2009	2:20 p.m.-3:05 p.m.	Prepare regulatory update on final DMHC timely access regulations	0.75	$390	$293
12/22/2009	8:30 a.m.-10:30 a.m.	Prepare regulatory update on final DMHC timely access regulations	2	$390	$780
1/6/2010	9:00 a.m.-11:00 a.m., 1:05 p.m.-1:50 p.m.	Prepare regulatory update on final DMHC timely access regulations	2.75	$390	$1,073
SUBTOTAL		**Elizabeth Abbott**	**168.75**		**$65,233**
TOTAL		**Hours**	**390.75**	**Amount**	**$142,510**

Hourly Rate Determinations are based on past award amounts,
and the PUC adopted ranges for non-attorney experts.

The billed hourly rate was increased annually by 3% COLA from year 2004 through 2008.
No COLA increase was included for 2008 - 2010.

Years of Experience	2006	2007	2008
0 - 6		$120 - $180	$125 - $185
7 - 12		$150 - $260	$155 - $270
13+		$15 - $380	$155 - $390
All Years	$115 - $370		